

Employer: SLAVIN & SLAVIN

Group Number: 600662

CERTIFICATE OF INSURANCE

Humana Insurance Company

This Certificate is not an insurance policy. It is an outline of the insurance provided by the group policy and it does not extend or change the coverage afforded by such group policy. The insurance described by this Certificate is subject to all the provisions, terms, exclusions and conditions of the group policy.

This Certificate supersedes and replaces any Certificate previously issued under the provisions of the group policy.

IMPORTANT NOTICE

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. **YOU CAN EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.** Non-participating providers may bill members for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for service with no additional billing to the member other than coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

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SCHEDULE OF BENEFITS

BENEFITS ARE PAYABLE ONLY IF SERVICES ARE CONSIDERED TO BE A COVERED EXPENSE AND ARE MEDICALLY NECESSARY. ALL COVERED SERVICES ARE PAYABLE ON A MAXIMUM ALLOWABLE FEE BASIS AND ARE SUBJECT TO SPECIFIC CONDITIONS, DURATIONAL LIMITATIONS AND ALL APPLICABLE MAXIMUMS OF THIS POLICY.

This Schedule of Benefits is part of Your Certificate.

The benefits outlined in this Schedule of Benefits are a summary of coverage and limitations provided under this group Policy. A more detailed explanation of Your coverage, limitations and exclusions is also provided in Your Certificate. Please refer to the Certificate and any applicable riders for additional coverage and/or limitations.

PREFERRED PROVIDER ORGANIZATION PROVISION

Your Certificate contains a Preferred Provider Organization Provision. Benefits may be paid at an increased percentage if Services are provided by a Preferred Provider. Please see the schedule of Medical Benefits and Covered Services.

PRESERVICE NOTIFICATION

Your Certificate contains procedures You must follow if You or a covered Dependent are to be admitted to a Hospital or Qualified Treatment Facility or are to have non-emergency outpatient Surgery. These procedures are described in the Utilization Management section of Your Certificate.

If You do not notify Us prior to an inpatient Confinement or non-emergency outpatient Surgery, benefits will NOT be payable for the first \$500 of Covered Expense.

The \$500 penalty is NOT applied to the Deductible or Out-of-Pocket limits shown on this Schedule of Benefits.

PREAUTHORIZATION REQUIREMENTS

Your Certificate contains procedures You must follow if You or a Covered Dependent are to receive Services from a Skilled Nursing Facility, Hospice Facility or Home Health Care Provider. These procedures are described in the Covered Services section of Your Certificate.

SCHEDULE OF BENEFITS (continued)

Lifetime Maximum Benefit per Covered Person.....\$5,000,000

Calendar Year Deductible:

- \$250 per Covered Person when You see a Preferred Provider
- \$250 per Covered Person when You see a Non-Preferred Provider

Any Covered Expense incurred by You during the last three months of the calendar year that is used to satisfy all or part of the Deductible for that calendar year will be used to satisfy all or part of the Deductible for the following Calendar Year.

Maximum Family Calendar Year plan Deductible:

- Covered Expenses applied to each Covered Person's plan Deductible are combined to a maximum family Deductible of \$750.

Out-of-Pocket Limit

Individual Out-of-Pocket Limit:

After the Deductible, if all the combined Covered Expense You pay for Coinsurance totals:

- \$1,000 when You see a Preferred Provider; and
- \$6,000 when You see a Non-Preferred Provider

in a calendar year, We will then pay Covered Expense at 100% for the remainder of that calendar year, subject to copayments, if any, and the Lifetime Maximum Benefit. The combined Preferred Provider and Non-Preferred Provider Out-of-Pocket Limit is \$6,000 after the Deductible.

Family Out-of-Pocket Limit:

If the combined Covered Expense You and Your Covered Dependents pay for Deductible and Coinsurance totals:

- \$3,750 when You or Your Covered Dependents see a Preferred Provider; and
- \$18,750 when You or Your Covered Dependents see a Non-Preferred Provider

in a calendar year, We will then pay Covered Expense at 100% for the remainder of that calendar year, subject to copayments, if any, and the Lifetime Maximum Benefit. The combined Preferred Provider and Non-Preferred Provider Out-of-Pocket Limit is \$18,750 including the Deductible.

SCHEDULE OF BENEFITS (continued)

ALL SERVICES ARE SUBJECT TO ALL THE TERMS AND PROVISIONS,
LIMITATIONS AND EXCLUSIONS OF THE POLICY

SUMMARY OF SERVICES

(DOES NOT INCLUDE MENTAL HEALTH COVERED SERVICES)

HOSPITAL SERVICES

Inpatient Care

- Semi-Private Room
- Intensive Care Unit
- Operating Room
- Ancillary Services

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

OUTPATIENT CARE (HOSPITAL ONLY) - ALL SERVICES

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

PHYSICIAN SERVICES

- Routine and Diagnostic Office visits
- Home visits billed by the physician
- Diagnostic Radiology, Laboratory, Pathology when performed in the office and billed by the physician (copayment does not apply)

PREFERRED PROVIDER BENEFITS: \$20 copayment per visit; 100% to a maximum of \$200 per visit, then 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

SCHEDULE OF BENEFITS (continued)

PHYSICIAN SERVICES

- Hospital visits
- Anesthesiologist
- Surgeon
- Assistant Surgeon allowed at 20% of the Covered Expense for the Surgery

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

DIAGNOSTIC RADIOLOGY, LABORATORY AND PATHOLOGY (NOT PERFORMED IN THE OFFICE)

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

EMERGENCY CARE

- Emergency Room

PREFERRED PROVIDER BENEFITS: \$75 copayment per visit (waived if admitted), then 90% to Out-of-Pocket Limit

NON-PREFERRED PROVIDER BENEFITS: \$75 copayment per visit (waived if admitted), then 90% to Out-of-Pocket Limit

- Emergency Room visit by the physician

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

PHYSICAL MEDICINE/THERAPY

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

SCHEDULE OF BENEFITS (continued)

DURABLE MEDICAL EQUIPMENT

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

AMBULANCE

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

PRENATAL CARE

Maximum benefit is \$200 per pregnancy for any female Covered Person

PREFERRED PROVIDER BENEFITS: 100% (Deductible does not apply)

NON-PREFERRED PROVIDER BENEFITS: 100% (Deductible does not apply)

COLORECTAL CANCER SCREENING

PREFERRED PROVIDER BENEFITS: 100% (Deductible does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit (Deductible does not apply)

ROUTINE MAMMOGRAM, PAP SMEAR AND PSA TEST

Does not include related office visits

PREFERRED PROVIDER BENEFITS: 100% (Deductible does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit (Deductible does not apply)

IMMUNIZATIONS TO AGE 18

Does not include related office visits

PREFERRED PROVIDER BENEFITS: 100% (Deductible does not apply)

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit (Deductible does not apply)

SCHEDULE OF BENEFITS (continued)

HOSPICE CARE

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

HOME HEALTH CARE

Must be in lieu of a **Hospital Confinement or Skilled Nursing Facility**

100 Home Health Care Visits per calendar year

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

SKILLED NURSING FACILITY

30 days per calendar year

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

NORMAL PREGNANCY:

Covered as any other Sickness for any female Covered Person.

SCHEDULE OF BENEFITS - MENTAL HEALTH

ALL SERVICES ARE SUBJECT TO ALL THE TERMS AND PROVISIONS,
LIMITATIONS AND EXCLUSIONS OF THE POLICY

SUMMARY OF SERVICES

MENTAL DISORDERS

INPATIENT CARE

Limited to 10 days per calendar year maximum benefit

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

SUMMARY OF SERVICES

MENTAL DISORDERS

OUTPATIENT CARE AND OFFICE THERAPY

Limited to 15 visits per calendar year maximum benefit

PREFERRED PROVIDER BENEFITS: 50% after Deductible (Does not apply to Your Out-of-Pocket limit)

NON-PREFERRED PROVIDER BENEFITS: 50% after Deductible (Does not apply to Your Out-of-Pocket limit)

SUBSTANCE ABUSE (CHEMICAL AND ALCOHOL DEPENDENCE)

Limited to the calendar year maximum* and lifetime maximum of the Policy

HOSPITAL OUTPATIENT AND INTERMEDIATE CARE*

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

PHYSICIAN OUTPATIENT AND INTERMEDIATE CARE*

PREFERRED PROVIDER BENEFITS: 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

SCHEDULE OF BENEFITS - MENTAL HEALTH (continued)

OFFICE VISITS AND HOME VISITS

PREFERRED PROVIDER BENEFITS: \$20 copayment per visit, 100% to a maximum of \$200 per visit, then 90% to Out-of-Pocket Limit after Deductible

NON-PREFERRED PROVIDER BENEFITS: 70% to Out-of-Pocket Limit after Deductible

* Outpatient and intermediate care and office and home visits combined will not exceed the calendar year maximum. The calendar year maximum benefit is adjusted annually in accordance with the U.S. Consumer Price Index. Contact Us for the current calendar year maximum benefit payable by the Policy.

SCHEDULE OF BENEFITS

PRE-EXISTING CONDITION EXCLUSION

If You received medical attention (medical attention means care, advice, examination, treatment, services, medication, procedures, test, consultation, referral or diagnosis) for a condition during the 6 months prior to Your Enrollment Date, such condition will be subject to the **Pre-Existing Condition** exclusion.

The **Pre-Existing Condition** exclusion will not exceed 6 months from Your Enrollment Date.

A diagnosis is not required for a physical or mental condition to be a **Pre-Existing Condition**. Genetic information, in itself, is not considered a condition. Pregnancy, when covered under Your Plan, is not subject to the **Pre-Existing Condition** exclusion.

The **Pre-Existing Condition** exclusion will NOT apply to:

- A newborn child who is covered on his/her date of birth; or
- A legally adopted child, including a child placed with the Employee for the purpose of adoption, if coverage is effective on the child's eligibility date.

PORTABILITY OF CREDITABLE COVERAGE

You are eligible for Portability of Creditable Coverage if Your coverage was continuous without a break of more than 63 days between the termination of coverage under **Creditable Coverage** and the Enrollment Date under this Policy.

The **Pre-Existing Condition** exclusion period will be reduced by the number of days of coverage that You had under the **Creditable Coverage**, if Your coverage was continuous to a date NOT more than 63 days prior to the Enrollment Date under this Policy.

If You are a **Late Applicant**, the **Pre-Existing Condition** exclusion period will be reduced by the number of days of coverage that You had under the **Creditable Coverage**, if Your coverage was continuous to a date NOT more than 63 days prior to the date We receive the enrollment form.

If on a particular day You have **Creditable Coverage** from more than one source, all the **Creditable Coverage** on that day will be counted as one day. Any waiting period for a Plan or Policy is counted toward determining whether there has been a 63-day break in coverage.

NOTICE:

You must submit to Us certification of **Creditable Coverage** from Your prior plan(s). Upon request and authorization from You, We can contact Your prior carrier(s) for Your **Creditable Coverage** certification.

DEFINITIONS

The following are definitions of terms as they are used in this Certificate. Defined terms are printed in bold face type wherever found in this Certificate.

ACTIVE STATUS

Active Status means the **Employee** is performing all of his/ her customary duties whether performed at the **Employer's** business establishment or another location when required to travel on the job:

1. On a regular full-time basis;
2. For the number of hours per week shown on the Employer Group Application;
3. For 48 weeks a year; and
4. Is maintaining a bona fide employee-employer relationship with the sponsor of this group Policy on a regular basis.

Each day of a regular vacation and any regular non-working holiday is deemed **Active Status**, if he or she was in **Active Status** on his or her last regular working day prior to the vacation or holiday. **You** are deemed to be in **Active Status**, if **Your** absence from work is due to a **Sickness** or **Bodily Injury**, provided **You** otherwise meet the definition of **Employee**.

BODILY INJURY

Bodily Injury means injury due directly to an accident. Muscle strain due to athletic or physical activity is considered a **Sickness**.

COINSURANCE

Coinsurance means the percentage of the **Covered Expense** that **You** are responsible for until **You** reach the **Out-of-Pocket Limit** as shown on **Your** Schedule of Benefits.

COMPLICATIONS OF PREGNANCY

Complications of Pregnancy means:

1. Conditions with diagnoses which are distinct from pregnancy but adversely affected by pregnancy or caused by pregnancy. Such conditions include: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; puerperal infection; toxemia; eclampsia; and missed abortion;
2. A nonelective cesarean section;
3. Terminated ectopic pregnancy; or
4. Spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

DEFINITIONS (continued)

Complications of Pregnancy does NOT mean:

1. False labor;
2. Occasional spotting;
3. Rest prescribed during the period of pregnancy;
4. Conditions associated with the management of a difficult pregnancy but which do not constitute distinct **Complications of Pregnancy**; or
5. An elective cesarean section.

CONFINEMENT

Confinement means being a resident patient in a **Hospital** or **Qualified Treatment Facility** for at least 15 consecutive hours. **Confinement** does not mean detainment in **Observation Status**.

Successive **Confinements** are considered to be one **Confinement** if:

1. Due to the same **Bodily Injury** or **Sickness**; and
2. Separated by fewer than 30 consecutive days when **You** are not confined.

COSMETIC SURGERY

Cosmetic Surgery means **Surgery** performed to reshape normal structures of the body in order to improve **Your** appearance and self-esteem.

COVERED EXPENSE

Covered Expense means:

1. A **Medically Necessary** expense;
2. For the benefits stated in this Certificate; and
3. An **Expense Incurred** when **You** are insured for that benefit under this Policy on the date that the **Service** is rendered.

Covered Expense is payable on a **Maximum Allowable Fee** basis and as shown on **Your** Schedule of Benefits, up to any maximum benefit.

DEFINITIONS (continued)

COVERED PERSON

Covered Person means the Employee and/or the Employee's covered Dependents.

CREDITABLE COVERAGE

Creditable Coverage means coverage under the following:

1. A Group health plan including governmental or church plans;
2. Individual or group health insurance;
3. Medicare (Part A or Part B);
4. Medicaid;
5. Military-sponsored health care;
6. A program of Indian Health Service or medical care under a tribal organization;
7. A State High Risk Health Benefit Pool;
8. The Illinois Children's Health Insurance Program;
9. Federal Employee Health Benefit Plan (FEHBP);
10. A public Health Plan;
11. A Health Plan run by the Peace Corps Act; or
12. Foreign health care.

Creditable Coverage does not include coverage under accident only, disability, liability, credit-only, workers' compensation or similar insurance, automobile medical payment insurance, coverage for on-site medical clinics or other similar insurance. It also does not include a health Flexible Spending Account (FSA), if it meets the Internal Revenue Service Definition of a health FSA, and You have other coverage available under a group health plan; and Your maximum benefit payable under the FSA does not exceed two times Your salary election. If Your maximum benefit payable under the FSA is greater than two times Your salary election, it must not exceed more than \$500 plus Your salary election.

DEFINITIONS (continued)

CUSTODIAL CARE

Custodial Care means Services given to You if:

1. You need Services including, but not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication which is ordinarily self administered, getting in and out of bed, maintaining continence; or
2. The Services You require are not likely to improve Your condition.

Services may still be considered Custodial Care by Us even if:

1. You are under the care of a physician; or
2. The physician prescribed Services are to support or maintain Your condition; or
3. Services are being provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.); or
4. Services involve the use of skills which can be taught to a lay person; or
5. You do not require the technical skills of a licensed nurse at all times.

DEDUCTIBLE

1. **Individual Deductible** means the amount of Covered Expense that a Covered Person is responsible to pay per calendar year before any benefits are payable by Us with respect to that Covered Person.
2. **Maximum Family Deductible** means the amount of Individual Deductibles that a family must pay. Once met, any remaining Individual Deductibles will be waived for that calendar year.

DENTAL INJURY

Dental Injury is an injury caused by a sudden, violent, and external force that could not be predicted in advance and could not be avoided. It does not include chewing injuries.

DEPENDENT

Dependent means a covered Employee's:

1. Legally recognized spouse; or
2. Unmarried natural blood related child, step-child, or legally adopted child whose age is less than the limiting age. Adopted child includes a child who is in the custody of the Employee, pursuant to an interim court order of adoption vesting temporary care of the child to You, regardless of whether a final order granting adoption is ultimately issued.

DEFINITIONS (continued)

Under no circumstances shall **Dependent** mean a grandchild, great grandchild, foster child or **Emancipated Minor** unless the child meets all of the qualifications of a dependent as determined by the Internal Revenue Service.

The limiting age for each **Dependent** child is:

1. The child's 19th birthday; or
2. For medical coverage only, the child's 25th birthday if such child is in regular full-time attendance at an accredited secondary school, college or university. The **Dependent** child must be enrolled for sufficient course credits to maintain full-time status as defined by that school. A **Dependent** child continues to be eligible for coverage for up to four months following the close of a school term only if enrolled as a full-time student for the following school term.

You must furnish satisfactory proof to Us upon Our request that the above conditions continuously exist. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

A covered **Dependent** child who becomes an employee eligible for other group coverage through employment is no longer eligible as a **Dependent** for coverage under this Policy.

A covered **Dependent** child who attains the limiting age WHILE INSURED under this Policy remains eligible for Medical Expense Benefits if:

1. Mentally retarded or permanently physically handicapped;
2. Incapable of self-sustaining employment;
3. The child meets all of the qualifications of a **Dependent** as determined by the Internal Revenue Service;
4. Declared on and legally qualified as a **Dependent** on the Employee's federal personal income tax return filed for each year of coverage; and
5. Unmarried.

You must furnish satisfactory proof to Us upon Our request that the above conditions continuously exist on and after the date the limiting age is reached. After two years from the date the first proof was furnished, We may not request such proof more often than annually. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

DEFINITIONS (continued)

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment means equipment that must:

1. Be able to withstand repeated use;
2. Be primarily and customarily used to serve a medical purpose;
3. Not be generally useful to a person except for the treatment of a Bodily Injury or Sickness; and
4. Be Medically Necessary.

EMANCIPATED MINOR

Emancipated Minor means a child who has not yet attained full legal age, but who has been declared by a court to be emancipated.

EMERGENCY CARE

Emergency Care means Services provided for a Bodily Injury or Sickness manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of immediate medical attention to result in:

1. Placing Your health, or if You are pregnant, Your or Your unborn child's health, in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Care does not mean Services for the convenience of the Covered Person or the provider of treatment or Services.

EMPLOYEE

Employee means a person who is permanently employed, in an Active Status at the Employer's place of business, and paid a salary or a wage by the Employer that meets the minimum wage requirements of Your state or federal minimum wage law. Employee also includes a sole proprietor, partner or corporate officer where:

1. The Employer is a sole proprietorship, partnership or corporation; and
2. The sole proprietor, partner or corporate officer is actively performing activities relating to the business, and gains their livelihood from the sole proprietorship, partnership or corporation and is in an Active Status at the Employer's place of business.

DEFINITIONS (continued)

EMPLOYER

Employer means the sponsor of this Group Insurance Plan, or any subsidiary described in the Employer Group Application. To be covered by this Plan, an **Employer** must meet the definition of **Employee**.

ENROLLMENT DATE

If You are NOT a Late Applicant, **Your Enrollment Date** is the earlier of the following:

1. The first day **Your** coverage is effective under this Policy; or
2. The first day of the waiting period for enrollment, if any waiting period is applicable.

Your Enrollment Date is the first day **Your** coverage is effective under this Policy, if:

1. You are a Late Applicant; or
2. You are enrolled on a **Special Enrollment Date**.

EXPENSE INCURRED

Expense Incurred means the **Maximum Allowable Fee** charged for **Services** which are **Medically Necessary** to treat the condition. The date a **Service** is rendered is the **Expense Incurred** date.

EXPERIMENTAL, INVESTIGATIONAL or for RESEARCH PURPOSES

A **Service** is **Experimental, Investigational or for Research Purposes** if We determine:

1. The **Service** cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the **Service** is furnished; or
2. The **Service** or **Your** informed consent document utilized with the **Service** was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval; or
3. Reliable Evidence shows that the **Service** is the subject of on-going phase I or phase II clinical trials; is the research, experimental, study or investigational arm of ongoing phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Reliable Evidence shows that the prevailing opinion among experts regarding the **Service** is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.
5. Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same **Service**; or the written informed consent used by the treating facility or by another facility studying substantially the same **Service**.

DEFINITIONS (continued)

FAMILY MEMBER

Family Member means You or Your spouse, or You or Your spouse's child, brother, sister, or parent.

FREE-STANDING SURGICAL FACILITY

A Free-Standing Surgical Facility means any licensed public or private establishment which has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgery. It does NOT provide services or accommodations for patients to stay overnight.

HEALTH INSURANCE COVERAGE

Health Insurance Coverage means medical coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or HMO contract offered by a Health Insurance Issuer; Health Insurance Issuer means an Insurance Company, Insurance Service, Insurance Organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance.

HOME HEALTH CARE PROVIDER

Home Health Care Provider means an agency licensed by the proper authority as a Home Health Agency, or Medicare Approved as a Home Health Agency and provides 24-hour-a-day, 7-day-a-week Service, supervised by a Qualified Practitioner.

HOME HEALTH CARE PLAN

Home Health Care Plan means a plan of health care established with a Home Health Care Provider. The Home Health Care Plan consists of:

1. Care by or under the supervision of a registered nurse (R.N.); or
2. Physical, speech, occupational, respiratory therapy, or
3. Medical appliances and equipment, if such supplies would have been covered if You were Hospital confined.

A Qualified Practitioner must:

1. Review and approve the Home Health Care Plan; and
2. Certify and verify the Home Health Care Plan is required in lieu of continued Hospital, Qualified Treatment Facility or Skilled Nursing Facility Confinement; and
3. Not be related to the Home Health Care Provider by ownership or contract.

DEFINITIONS (continued)

HOME HEALTH CARE VISIT

Home Health Care Visit means Services provided by any one Qualified Practitioner for four (4) consecutive hours or any portion thereof.

HOSPICE CARE AGENCY

Hospice Care Agency means an agency which:

1. Has the primary purpose of providing hospice services to Hospice Patients;
2. Is licensed and operated according to the laws of the state in which it is located; and
3. Meets all of these requirements:
 - A. Has obtained any required certificate of need;
 - B. Provides 24-hour-a-day, 7-day-a-week Service, supervised by a qualified physician;
 - C. Has a full-time administrator;
 - D. Keeps written records of Services provided to each patient;
 - E. Has a coordinator who:
 - i). Is an R.N.;
 - ii). Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
 - F. Has a licensed social service coordinator.

HOSPICE CARE PROGRAM

Hospice Care Program means a written plan of hospice care which:

1. Is established and reviewed by:
 - A. The Qualified Practitioner attending the person; and
 - B. The Hospice Care Agency; and
2. Provides:
 - A. Palliative and supportive care to Hospice Patients;
 - B. Supportive care to the families of Hospice Patients;
 - C. An assessment of the Hospice Patient's medical and social needs; and
 - D. A description of the care to meet those needs.

DEFINITIONS (continued)

HOSPICE FACILITY

Hospice Facility means a licensed facility or part of a facility which:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;
4. Has a physician on call at all times;
5. Provides 24-hour-a-day skilled nursing Services under the direction of an R.N.; and
6. Has a full-time administrator.

HOSPICE PATIENT

Hospice Patient means a terminally ill person with six months or less to live.

HOSPITAL

Hospital means an institution which:

1. Maintains permanent full-time facilities for bed care of resident patients;
2. Has a physician or surgeon in regular attendance;
3. Provides continuous 24-hour-a-day nursing Services;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical or surgical care of sick or injured persons;
5. Is legally operated in the jurisdiction where located; and
6. Has surgical facilities on its premises or has a contractual agreement for surgical Services with an institution having a valid license to provide such surgical Services; or
7. Is a lawfully operated Qualified Treatment Facility certified by the First Church of Christ Scientist, Boston, Massachusetts.

Hospital does NOT include an institution which is principally a rest home, nursing home, convalescent home or home for the aged. Hospital does NOT include a place principally for the treatment of alcohol or chemical dependency or Mental Disorders.

DEFINITIONS (continued)

MAINTENANCE CARE

Maintenance Care means any **Service** or activity which seeks to prevent disease, prolong life or promote health of an asymptomatic **Covered Person** who has reached the maximum level of improvement and whose condition is resolved or stable.

MAXIMUM ALLOWABLE FEE

Maximum Allowable Fee for a **Covered Expense** is the lesser of:

1. The fee charged by the provider for the **Services**;
2. The fee that has been negotiated with the provider whether directly or through one or more intermediary, or shared savings contracts for the **Services**;
3. The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar **Services** from a geographic area determined by Us;
4. The fee based on rates negotiated with one or more participating providers in a geographic area determined by Us for the same or similar **Services**;
5. The fee equal to the provider's costs for providing the same or similar **Services** as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare and Medicaid Services (CMS) annually; or
6. The fee based on a percentage of the fee Medicare allows for the same or similar **Services** provided in the same geographic area.

NOTE: The bill You receive for **Services** from nonparticipating providers may be significantly higher than the **Maximum Allowable Fee**. In addition to Your **Out-of-Pocket Deductibles** and **Coinsurance**, You are responsible for the difference between the **Maximum Allowable Fee** and the amount the provider bills You for the **Services**. Any amount You pay to the provider in excess of the **Maximum Allowable Fee** will not apply to Your **Out-of-Pocket Limit** or **Deductible**.

MEDICALLY NECESSARY

Medically Necessary means the extent of **Services** required to diagnose or treat a **Bodily Injury** or **Sickness** which is known to be safe and effective by the majority of **Qualified Practitioners** who are licensed to diagnose or treat that **Bodily Injury** or **Sickness**. Such **Services** must be:

1. Performed in the least costly setting required by Your condition;
2. Not provided primarily for the convenience of You or the **Qualified Practitioner**;
3. Consistent with Your symptoms or diagnosis of the **Sickness** or **Bodily Injury** under treatment;
4. Furnished for an appropriate duration and frequency in accordance with accepted medical practices, and which are appropriate for Your symptoms, diagnosis, or **Sickness** or **Bodily Injury**; and
5. Substantiated by the records and documentation maintained by the provider of **Service**.

DEFINITIONS (continued)

MENTAL DISORDER

Mental Disorder means mental, nervous, or emotional diseases or disorders of any type as classified in the Diagnostic and Statistical Manual of Mental Disorders. This is true regardless of the original cause of the disorder.

MORBID OBESITY

Morbid obesity (clinically severe obesity) means a body mass index (BMI) as determined by a healthcare practitioner as of the date of service of:

- 40 kilograms or greater per meter squared (kg/m²); or
- 35 kilograms or greater per meter squared (kg/m²) with an associated comorbid condition such as hypertension, type II diabetes, life-threatening cardiopulmonary conditions; or joint disease that is treatable, if not for the obesity.

NETWORK

Network means a group of providers who have entered into a contract with Us to provide Services at negotiated rates.

OBSERVATION STATUS

Observation Status means a stay in a Hospital or Qualified Treatment Facility not to exceed 24 hours if:

1. You have not been admitted as an inpatient;
2. You are physically detained in an emergency room, treatment room, observation room or other such area; or
3. You are being observed to determine whether an inpatient Confinement will be required.

OUT-OF-POCKET LIMIT

1. Individual Out-Of-Pocket Limit means the amount of Deductible and Coinsurance that a Covered Person must pay before We will pay Covered Expense at 100%.
2. Family Out-of-Pocket Limit means the amount of Deductible and Coinsurance that You and Your covered Dependents must pay before We will pay Covered Expense at 100%.

DEFINITIONS (continued)

PREADMISSION TESTING

Preadmission Testing means only those outpatient x-ray and laboratory tests made within seven days before admission as a registered bed patient in a Hospital. The tests must be for the same Bodily Injury or Sickness causing You to be Hospital confined. The tests must be accepted by the Hospital in place of like tests made during Confinement. Preadmission Testing does NOT mean tests for routine physical check-ups.

PREAUTHORIZATION

Preauthorization means that prior approval is given by Us. Preauthorization review will determine if the proposed Service is a Covered Expense. Preauthorization is subject to the terms and provisions of this Policy.

PRE-EXISTING CONDITION

Pre-Existing Condition means a physical or mental condition for which You have received medical attention (medical attention means care, advice, examination, treatment, services, medication, procedures, tests, consultation, referral or diagnosis) during the six (6) months prior to Your Enrollment Date.

The time period for Pre-Existing Condition exclusion under this Policy is described on the Schedule of Benefits.

PRENATAL CARE

Prenatal Care means Covered Expense for obstetrical care received by any female Covered Person from a Qualified Practitioner.

PRESERVICE NOTIFICATION

Preservice Notification means notification to Us by You or a Qualified Practitioner of a proposed Service.

PRESERVICE REVIEW

Preservice Review means a review by Us, at Our option, of a proposed Service in a Hospital or Qualified Treatment Facility to determine:

1. If the proposed Service or Confinement is Medically Necessary; and
2. If the use of alternative care is appropriate, such as:
 - A. Skilled Nursing Facilities;
 - B. Home health care services;

DEFINITIONS (continued)

- C. Inpatient or outpatient **Hospice Care Programs**;
- D. Partial hospitalization;
- E. Intensive outpatient programs; or
- F. Any other alternatives.

QUALIFIED PRACTITIONER

Qualified Practitioner means a practitioner, professionally licensed by the appropriate state agency to diagnose or treat a **Bodily Injury or Sickness**, and who provides **Services** within the scope of that license. A **Qualified Practitioner's Services** are not covered if the practitioner resides in **Your home** or is **Your Family Member**.

QUALIFIED TREATMENT FACILITY

Qualified Treatment Facility means only a facility, institution, or clinic duly licensed by the appropriate state agency, and is primarily established and operating within the scope of its license.

SERVICES

Services means procedures, **Surgeries**, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices, or technologies.

SERIOUS MENTAL ILLNESS

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) IV-TM:

- Schizophrenia,
- Paranoid and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episode or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive developmental disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.
- Panic disorder;
- Post-traumatic stress disorders (acute, chronic, or with delayed onset).

DEFINITIONS (continued)

SICKNESS

Sickness means a disturbance in function or structure of Your body which causes physical signs or symptoms which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body.

SKILLED NURSING FACILITY

Skilled Nursing Facility means only an institution licensed as a Skilled Nursing Facility and lawfully operated in the jurisdiction where located. It must maintain and provide:

1. Permanent and full-time bed care facilities for resident patients;
2. A Qualified Practitioner's services available at all times;
3. 24-hour-a-day skilled nursing services under the full-time supervision of a physician or registered nurse (R.N.);
4. A daily record for each patient;
5. Continuous skilled nursing care for sick or injured persons during their convalescence from illness or injury; and
6. A utilization review plan in effect.

A Skilled Nursing Facility is not, except by incident, a rest home, a home for the care of the aged, or engaged in the care and treatment of chemical or alcohol dependence.

SMALL EMPLOYER

Small Employer means an Employer who employed an average of two (2) but not more than fifty (50) Employees on business days during the preceding calendar year and who employs at least two (2) Employees on the first day of the plan year, unless otherwise provided under State law. All entities that are affiliated or that are eligible to file combined tax return are considered one Employer.

SOUND NATURAL TOOTH

Sound Natural Tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than whole natural tooth.

DEFINITIONS (continued)

SPECIAL ENROLLMENT DATE

Special Enrollment Date means:

1. The date of change in family status after the initial Eligibility Date, as follows:
 - A. Date of marriage;
 - B. Date of birth of a natural born child; or
 - C. Date of adoption of a child or date of placement of a child with the Employee for the purpose of adoption; or
2. The date of termination of coverage under a group health plan or other Health Insurance Coverage, as specified under the Special Enrollment provision.

SURGERY

Surgery means excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

TOTAL DISABILITY

Total Disability or Totally Disabled means, for the Employee or Employee's employed covered Dependent spouse, that during the first 24 months of disability that person is at all times prevented by Bodily Injury or Sickness from performing each and every material duty of his or her respective job or occupation.

After the first 24 months, Total Disability or Totally Disabled means that person is at all times prevented by Bodily Injury or Sickness from engaging in any job or occupation for wage or profit for which he or she is reasonably qualified by education, training or experience.

For any Covered Dependent who is not employed, Total Disability means a disability preventing that person from performing the usual and customary activities of a person in good health and of the same age and gender.

A Totally Disabled person also may not engage in ANY job or occupation for wage or profit.

WE, US, and OUR

We, Us, and Our means the Insurance Company as shown on the cover page of this Certificate.

YOU and YOUR

You and Your means any Covered Person.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

ELIGIBILITY DATE

EMPLOYEE ELIGIBILITY DATE

The Employee is eligible for coverage on the date:

1. The eligibility requirements stated in the Employer Group Application are satisfied; and
2. The Employee is in an Active Status.

DEPENDENT ELIGIBILITY DATE

Each Dependent is eligible for coverage on:

1. The date the Employee is eligible for coverage, if he or she has Dependents who may be covered on that date;
2. The date of the Employee's marriage for any Dependents (spouse or child) acquired on that date;
3. The date of birth of the Employee's natural-born child;
4. The date the child is placed in the Employee's home for the purpose of adoption by the Employee; or
5. The date specified in the court or administrative order, which requires the Employee to provide coverage for a child or spouse as specified in such order, if You are eligible for Dependent coverage.

The Employee may cover his or her Dependents ONLY if the Employee is also covered.

A Dependent child who becomes eligible for other group coverage through any employment is no longer eligible for group coverage under this Policy. If a Dependent child becomes an Employee of the participating Employer, he or she is no longer eligible as a Dependent and must make application as an eligible Employee.

ENROLLMENT

EMPLOYEE ENROLLMENT

The Employee must enroll on forms furnished and accepted by Us. Depending on the total number of Employees covered by the Employer's plan, We may require any Employee to provide evidence of health status whenever an enrollment form is submitted.

If You enroll more than 31 days after Your eligibility date or more than 31 days after Your Special Enrollment Date, You are a Late Applicant.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE (continued)

DEPENDENT ENROLLMENT

Check with the **Employer** immediately on how to enroll for **Dependent** coverage. The **Employee** must enroll for **Dependent** coverage and enroll additional **Dependents** on forms furnished and accepted by Us.

Depending on the total number of **Employees** covered by the **Employer's** plan, **We** may require any **Dependent** to provide evidence of health status whenever an enrollment form is submitted.

A **Dependent** enrolled more than 31 days after the **Dependent's** eligibility date or the **Special Enrollment Date** will be a **Late Applicant**.

NEWBORN DEPENDENT ENROLLMENT

An **Employee** who already has **Dependent** child coverage in force **PRIOR** to the newborn's date of birth is not required to complete an enrollment form for the newborn child.

An **Employee** who does not have **Dependent** child coverage must complete an enrollment form for the newborn **Dependent**. This form is available from **Your Employer** or from Us.

SPECIAL ENROLLMENT

LOSS OF OTHER COVERAGE

If **You** are an **Employee** or **Dependent** who was previously eligible for coverage under this Plan and had waived coverage, **You** may be eligible for the **Special Enrollment** provision. **You** will not be considered a **Late Applicant**, if the following applies:

1. **You** declined enrollment under this Plan at the time of initial enrollment because:
 - A. **You** were covered under a group health plan or other **Health Insurance Coverage** at the time of eligibility; and **Your** coverage terminated as a result of:
 - i) Termination of employment or eligibility;
 - ii) Reduction in number of hours of employment;
 - iii) Divorce, legal separation or death of a spouse; or
 - iv) Termination of **Your Employer's** contribution for the coverage; or
 - B. **You** had **COBRA** continuation coverage under another Plan at the time of eligibility and such coverage has since been exhausted; and
 - C. **You** stated, at the time of the initial enrollment, that coverage under the group health plan or other **Health Insurance Coverage** or **COBRA** continuation was **Your** reason for declining enrollment; and

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

(continued)

- D. You apply for coverage within 31 days after termination of coverage under the group health plan or other Health Insurance Coverage or COBRA; or
2. You were covered under an alternate Plan provided by the Employer and You are replacing coverage with this Plan.

DEPENDENT SPECIAL ENROLLMENT PERIOD

The Special Enrollment Period is a 31 day period from the Special Enrollment Date.

If Dependent coverage is available under the Employer's group Plan or added to the Plan, an Employee who is a Covered Person can enroll eligible Dependents during the Special Enrollment Period. An Employee, who is otherwise eligible for coverage and had waived coverage under this Plan when eligible, can enroll himself/ herself and eligible Dependents during the Special Enrollment Period. The Employee or Dependent enrolling within 31 days from the Special Enrollment Date will not be considered a Late Applicant.

EMPLOYEE EFFECTIVE DATE

The Employee's Effective Date Provision is stated in the Employer Group Application. It may be the date immediately following, or the first of the month following, completion of the probationary period, or the Special Enrollment Date.

Effective date is the first date of coverage under this Plan.

If You enroll more than 31 days after Your eligibility date or the Special Enrollment Date, You are a Late Applicant. The effective date of coverage will be the first of the month following the receipt of the enrollment form.

EMPLOYEE DELAYED EFFECTIVE DATE

If the Employee is not in Active Status on the eligibility date, coverage will be effective the day after the Employee returns to Active Status. The Employer must notify Us in writing of the Employee's return to Active Status.

DEPENDENT EFFECTIVE DATE

1. If We receive the enrollment form on, prior to or within 31 days of the Dependent's eligibility date that Dependent is covered on the date he or she is eligible:
2. If We receive the enrollment form on, prior to or within 31 days of the Dependent's Special Enrollment Date, that Dependent's coverage is effective on the Special Enrollment Date.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

(continued)

3. If We receive the enrollment form more than 31 days after the **Dependent's** eligibility date or the **Special Enrollment Date**, that **Dependent** is considered a Late Applicant. The effective date of coverage will be the first of the month following the receipt of the enrollment form.

However, NO **Dependent's** effective date will be prior to the **Employee's** effective date of coverage.

NEWBORN DEPENDENT EFFECTIVE DATE

A newborn **Dependent's** effective date is determined as follows:

1. If We receive the enrollment form on, prior to or within 31 days of the newborn's date of birth, **Dependent** coverage is effective on the newborn's date of birth.
2. If We receive the enrollment form more than 31 days after the newborn's date of birth, the newborn is considered a Late Applicant. The newborn's effective date of coverage will be the first of the month following the receipt of the enrollment form.

BENEFIT CHANGES

Benefit changes will become effective on the date specified by Us, if the **Employee** is in **Active Status** on that date. Otherwise, the change will be effective on the day the **Employee** returns to **Active Status**.

RETIRED EMPLOYEE COVERAGE

RETIRED EMPLOYEE ELIGIBILITY DATE

Retired **Employees** are an eligible class of **Employees** if requested on the Employer Group Application and if approved by Us. An **Employee** who retires WHILE INSURED under this Policy is considered eligible for Retired **Employee** medical coverage on the date of retirement if the eligibility requirements stated in the Employer Group Application are satisfied.

RETIRED EMPLOYEE ENROLLMENT

Notification of the **Employee's** retirement must be submitted to Us by the Employer within 31 days of the date of retirement. If We receive the notification more than 31 days after the date of retirement, You will be considered a Late Applicant.

ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE
(continued)

RETIRED EMPLOYEE EFFECTIVE DATE

The effective date of coverage for an eligible retired Employee is the date of retirement for an Employee who retires AFTER the date We approve the Employer's request for a retiree classification, provided We receive notice of the retirement within 31 days. If We receive notice more than 31 days after retirement, the effective date of coverage will be the date We specify.

RETIRED EMPLOYEE'S BENEFIT CHANGES

Additional or increased insurance or a decrease in insurance will become effective on the approved date of change.

TERMINATION OF COVERAGE

Termination of Coverage may be immediate or at the end of the period which was selected by Your Employer on the Employer Group Application.

Insurance terminates on the earliest of the following:

1. The date this Group Policy terminates;
2. The end of the period for which required premium was due Us and not received by Us;
3. The date the Employer's participation under this Policy terminates;
4. For the Employee, the date he or she terminates employment with the Employer;
5. For an Employee, the date he or she no longer qualifies as an Employee;
6. The date You fail to be in an eligible class of persons as provided in the Insurance Classifications as stated in the Employer Group Application;
7. The date You enter full-time military, naval or air service;
8. The date the Employee retires, except if the Employer Group Application provides coverage for a retiree class of Employees and the retiree is in an eligible class of retirees, selected by the Employer, and We are notified by the Employer;
9. The date the Employee requests termination of insurance to be effective for the Employee or Dependents;
10. For a Dependent, the date the Employee's insurance terminates;
11. For a Dependent, the date he or she no longer qualifies as a Dependent; or
12. For any benefit, the date the benefit is deleted from this Policy.

YOU AND THE EMPLOYER ARE RESPONSIBLE TO ADVISE US OF ANY CHANGES IN ELIGIBILITY INCLUDING THE LACK OF ELIGIBILITY OF ANY COVERED PERSON. COVERAGE WILL NOT CONTINUE BEYOND THE LAST DATE OF ELIGIBILITY REGARDLESS OF THE LACK OF NOTICE TO US.

SPECIAL PROVISIONS FOR NOT BEING IN ACTIVE STATUS

If the Employer continues to pay required premiums and continues participation under this Policy, Your coverage, other than Short Term Disability benefits, if any, will remain in force for:

1. No longer than three consecutive months if the Employee is:
 - A. Temporarily laid-off;
 - B. In part-time status; or

TERMINATION OF COVERAGE (continued)

C. On an Employer approved leave of absence.

2. No longer than 12 consecutive months if the Employee is Totally Disabled.

If the Employee becomes **Totally Disabled** and wishes to apply for Waiver of Premium, We must receive premium for Employee Term Life Coverage for the six consecutive month period while the Employee is covered under the Special Provisions for Not Being in Active Status. All premium must be submitted to Us through the Employer.

If this coverage terminates, the Employee may exercise the rights under any applicable Continuation of Medical Benefits provision, or the Medical or Life Conversion Privilege described in this Certificate. If the Employee utilizes the Conversion Privilege, he or she thereby waives the right to continue coverage. If the Employee returns to an Active Status, he or she will be considered a new Employee and must re-enroll for Employee Coverage.

CONTINUATION FOR LOSS OF EMPLOYMENT

If Your medical coverage under the Policy terminates due to loss of employment You may continue medical coverage for You and Your covered Dependents if:

1. You were covered under the Policy for at least three consecutive months immediately prior to termination;
2. You are not eligible for Medicare or other group coverage; and

You and Your Dependents are NOT eligible for continuation of medical coverage if You were discharged from Your employment due to commission of a felony or a theft in connection with Your work and for which the Employer was in no way responsible; provided that You have admitted to commission of the felony or theft or have been convicted or received an order of supervision by a court of competent jurisdiction for such act.

ENROLLMENT

The Employer will notify You in writing of Your right to continue coverage. If You elect to continue coverage You must notify the Employer in writing within ten days following:

1. The date Your coverage would otherwise terminate; or
2. The date You received written notification of Your right to continue coverage.

In no event will You be eligible to elect continuation of coverage more than 60 days after the date Your coverage would otherwise terminate.

If You elect to continue coverage You must pay the total monthly premium in advance to the Employer. The premium for continuing Your coverage will be the rate which would have been applicable to the Employer for Your group coverage during the continuation period.

TERMINATION OF COVERAGE (continued)

If **You** do not choose to continue **Your** group medical coverage, or if **You** do and it terminates, **You** have the right to exercise the Medical Conversion Privilege described in the Certificate. If **You** do not continue coverage and utilize the Conversion Privilege **You** thereby waive the right to continue coverage. The Medical Conversion Privilege is available to **Your** covered **Dependents** while **You** are insured under this continuation privilege.

TERMINATION

Medical coverage may be continued under this right until the earliest of the following:

1. 9 months after the date **You** coverage would otherwise have terminated;
2. The end of any month for which **You** fail to make timely payment of premium;
3. The date this Policy terminates or the date the **Employer** terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new policy;
4. The date **You** become eligible for Medicare or other group coverage; or
5. For **Your** **Dependent**, the date he or she no longer meets the definition of **Dependent**.

If the **Employee** returns to Active Status while insured under this continuation privilege, he or she must re-enroll for **Employee** Coverage.

CONTINUATION FOR MUNICIPAL EMPLOYEES

If **Your** medical coverage under the Policy terminates due to retirement or disability, **You** may continue medical coverage for **You** and **Your** covered **Dependents** if:

1. **You** are a participant in the Illinois Municipal Retirement Fund; and
2. **You** and **Your** covered **Dependents** are insured under the provisions of this group policy on the day immediately preceding the day on which **Your** retirement or disability begins.

DEFINITIONS

"Retirement " or "disability period" of an **Employee** means the period which begins on the day the **Employee** is removed from the municipality payroll because of the occurrence of either of the following events:

1. The **Employee** retires from active service as an **Employee** with an attained age and accumulated creditable service which together qualify the **Employee** for immediate receipt of retirement pension benefits under Article 7 of the Illinois Pension Code; or
2. The **Employee's** disability is established under Article 7 of the Illinois Pension Code.

TERMINATION OF COVERAGE (continued)

ENROLLMENT

Within 15 days of the beginning of the retirement or disability period of any eligible Employee, the municipality shall give written notice to Us. Within 15 days of receipt of such notice, We will give written notice to You of Your right to continue coverage. You must return the election from to Us by certified mail, return receipt requested, within 15 days of receiving it.

It is Your obligation to pay the monthly premium directly to the municipality for forwarding to Us, or to designate on the election form that the premium, or portion thereof, be deducted by the Illinois Municipal Retirement Fund from Your monthly pension payment and forwarded to Us by the Fund.

TERMINATION

Medical coverage may be continued until the earliest of the following:

1. Your reinstatement or reentry into active service as provided for under Article 7 of the Illinois Pension Code; or
2. Your exercise of any refund option or acceptance of any separation benefit available under Article 7 of the Illinois Pension Code; or
3. Your loss pursuant to Section 7-219 of the Illinois Pension Code of any benefits provided for in Article 7 of that Code; or
4. The Employee's death or, if at the time of the Employee's death the Employee is survived by a spouse who, in that capacity, is entitled to receive a surviving spouse's monthly pension pursuant to Article 7 of the Illinois Pension Code, the death or remarriage of that spouse.

SURVIVORSHIP CONTINUATION

If the Employee dies while Dependent Coverage is in force, the surviving Dependent spouse and Dependent children may continue to be insured for medical coverage only. Coverage may continue for 90 days after the death without application, subject to all terms and provisions of this Policy. This 90 day continuation will run concurrently with the following continuation that must be applied for.

CONTINUATION FOR DEPENDENTS DUE TO DIVORCE, DEATH OR RETIREMENT OF THE EMPLOYEE

If Your medical coverage under this Policy terminates due to legal annulment, dissolution of marriage, divorce, or the death of the Employee, or due to the retirement of the Employee (if You, the Dependent spouse, are age 55 or over at the time of retirement), You may continue medical coverage for You and Your covered Dependents if You:

1. Notify the Employer in writing within 30 days after the date Your coverage would otherwise terminate;
2. Elect to continue group medical coverage within 30 days after receipt of written notice of Your right to continue coverage; and

TERMINATION OF COVERAGE (continued)

3. Pay the total monthly premium in advance to the Employer. The premium for continuing Your coverage will be the rate which would have been applicable to the Employer for Your group coverage during the continuation period.

TERMINATION

If the former spouse has not attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:

1. Two years after the date the continued coverage began;
2. The date the former spouse remarries;
3. The end of any month for which You fail to make timely payment of premium;
4. The date coverage would terminate under the terms of the existing Policy if the Employee and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce or death of the Employee unless the policy is modified or terminated as to all Employees;
5. The date this Policy terminates or the date the Employer terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new Policy;
6. The date the former spouse first becomes an insured employee under any other group health plan after the date of election of continued coverage; or
7. For a Dependent child, the date no longer qualified as a Dependent.

If the former spouse or retiree's spouse has attained the age of 55 at the time the continuation coverage begins, coverage may be continued until the earliest of the following:

1. The date the former spouse remarries;
2. The end of any month for which You fail to make timely payment of premium;
3. The date coverage would terminate, except due to the retirement of an Employee, under the terms of the existing Policy if the Employee and former spouse were still married to each other; except that the continued coverage shall not be modified or terminated during the first 120 days following the divorce, death or retirement of the Employee unless this Policy is modified or terminated as to all Employees;
4. The date this Policy terminates or the date the Employer terminates participation under this Policy. If the Group Policy is replaced, coverage will continue under the new policy;
5. The date the retiree's spouse or the former spouse first becomes an insured Employee under any other group health plan after the date of election of continued coverage;
6. For a Dependent child, the date no longer qualified as a Dependent; or

TERMINATION OF COVERAGE (continued)

7. The date the retiree's spouse or former spouse reached the qualifying age or otherwise becomes eligible for Medicare.

CONTINUATION FOR DEPENDENT CHILDREN

If **You** (the covered **Dependent** child's) medical coverage under this Policy terminates either due to death of the **Employee** or due to attaining the limiting age as stated in this Certificate, **You** may continue medical coverage if **You** (or the responsible adult acting on **Your** behalf):

1. Notify the **Employer** in writing within 30 days of the date **Your** coverage would otherwise terminate;
2. Elect to continue group medical coverage within 30 days after the receipt of written notice of **Your** right to continue coverage; and
3. Pay the total monthly premium in advance to the **Employer**. The premium for continuing **Your** coverage will be the rate which would have been applicable to the **Employer** for **Your** group coverage during the continuation period.

TERMINATION

Coverage may be continued until the earliest of the following:

1. Two years after the date the continued coverage began;
2. The end of the month for which **You** fail to make timely payment of premium;
3. The date coverage would terminate under the terms of the existing Policy if **You** were still an eligible **Dependent** of the **Employee**; or
4. The date **You** first become an insured employee under any other group health plan after the date of election of continued coverage.

If **You** do not choose to continue **Your** group medical coverage, or if **You** do and it terminates, **You** have the right to exercise the Medical Conversion Privilege described in the Certificate. If **You** do not continue coverage and utilize the Conversion Privilege, **You** thereby waive the right to continue coverage. The Medical Conversion Privilege is available to **Your** covered **Dependents**, in lieu of, or at the termination of eligibility for, the Continuation Privilege, while **You** are insured under this Continuation Privilege.

MEDICAL CONVERSION PRIVILEGE

ELIGIBILITY

Subject to the terms below, if Your medical coverage under this Policy terminates, a Medical Conversion Policy is available without medical examination. You must have been covered under this Policy for at least 90 days and:

1. Your coverage ends because the Employee's employment terminated;
2. You were the covered Dependent spouse or any covered Dependent child of an Employee whose marriage ended due to legal annulment, dissolution of marriage or divorce;
3. You are the surviving covered Dependent spouse or covered Dependent child, in the event of the Employee's death or at the end of any "Survivorship Continuation" as provided by this Policy;
4. You have been a covered Dependent child but no longer meet the definition of Dependent under this Policy; or
5. Your group policy discontinues in its entirety or with respect to an insured class.

Only persons covered under this Policy on the date coverage terminates are eligible to be covered under the Conversion Policy.

The Conversion Policy may be issued covering each former Covered Person on a separate basis or it may be issued covering all former Covered Persons together. However, if conversion is due to dissolution of marriage by annulment or final divorce decree, only those persons who cease to be dependent on the Employee are eligible to exercise the Conversion Privilege.

This privilege does NOT apply when the Employer's participation in this Policy terminates and medical coverage is replaced within 31 days by another group insurance plan.

NOTICE

Election of Conversion coverage would eliminate Your federal eligibility for coverage under Illinois Comprehensive Health Insurance Plan (CHIP).

OVERINSURANCE-DUPLICATION OF COVERAGE

We may refuse to issue a Conversion Policy if We determine that You would be overinsured. The Medical Conversion Policy will not be available if it would result in overinsurance or duplication of benefits. We will use Our standards to determine overinsurance.

Where overinsurance DOES NOT exist but other insurance is in force, benefits payable under the Medical Conversion Policy may be reduced.

MEDICAL CONVERSION PRIVILEGE (continued)

CONVERSION PLAN

The Conversion Policy which You may apply for will be the Policy customarily offered by Us as a conversion from group coverage.

The Conversion Policy is a new Policy and not a continuation of Your terminated coverage. The Conversion Policy benefits will differ from those provided under Your group coverage. The benefits that may be available to You will be described in an Outline of Coverage provided to You when You request an application for Conversion from Us.

EFFECTIVE DATE AND PREMIUM

You have 31 days after the date Your coverage terminates to apply and pay the required premium for Your Conversion Policy. The premium must be paid in advance. You may obtain application forms from Us. The Conversion Policy will be effective on the day after Your Group Medical coverage ends, if You enroll and pay the first premium within 31 days after the date Your coverage ends.

The premium for the Conversion Policy will be the premium charged by Us as of the effective date based upon the Conversion Policy form, classification of risk, age and benefit amounts selected. The premium may change as provided in the Conversion Policy.

PREFERRED PROVIDER ORGANIZATION PROVISIONS

WHAT IS A PREFERRED PROVIDER ORGANIZATION?

Preferred Provider Organizations (PPO) are networks of **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers that are contracted to furnish, at negotiated fees, medical Services for **Employees** (and their covered **Dependents**) of participating **Employers**.

REASONS TO USE A PPO PROVIDER

1. We negotiate fees for medical Services. The negotiated fees lower costs for You when You use **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers in the PPO.
2. In addition, You may receive a better benefit and Your **Out-of-Pocket** expenses will be minimized.
3. You will have a wide variety of selected **Hospitals, Qualified Treatment Facilities, Qualified Practitioners**, and other providers in the PPO to help You with Your medical care needs.

In order to avoid reduced benefit payments, obtain Your medical care from Preferred Providers whenever possible. However, the choice of provider is Yours.

HOW TO SELECT A PROVIDER

A list of the participating **Hospitals, Qualified Treatment Facilities, Qualified Practitioners** and other providers in Your PPO will be given to You at the time Your coverage becomes effective. This list is subject to change. To confirm that Your **Hospital, Qualified Treatment Facility, Qualified Practitioner** or other provider is a current participant in Your PPO, you must call the number listed on the back of Your medical identification card.

If You are traveling or need emergency care and are unable to access care from Your PPO provider, benefits will be paid at the Non-Preferred Provider level.

MENTAL HEALTH COVERED SERVICES

The PPO Provisions may not include treatment received for **Mental Disorders**, Chemical or Alcohol dependence. Benefits for these conditions are shown under the Mental Health Covered Services provision of this Certificate and on Your Schedule of Benefits.

BENEFITS ARE PAYABLE AS SHOWN ON YOUR SCHEDULE OF BENEFITS.

UTILIZATION MANAGEMENT

PRESERVICE NOTIFICATION

This provision applies to all Confinements in a Hospital or Qualified Treatment Facility and non-emergency outpatient Surgeries in a Hospital or Qualified Treatment Facility. Nothing in this provision will increase benefits to cover a Confinement or Service which is not Medically Necessary or otherwise not covered under this Policy.

PRESERVICE NOTIFICATION PROCEDURES

WHAT YOU ARE REQUIRED TO DO:

If You or Your covered Dependent are to be admitted to a Hospital or Qualified Treatment Facility as an inpatient or for non-emergency outpatient surgery, You or Your Qualified Practitioner must contact Us by telephone or in writing at least seven days before Your admission. We must be notified of any Emergency admission within 48 hours after the admission or by the end of the first business day following the emergency which ever is later.

If You have pregnancy coverage and have not already notified Us as outlined under the Prenatal Care benefit, You must notify Us by telephone or in writing by the 20th week of pregnancy.

WHAT WE WILL DO:

We will advise You if Preservice Review and/or Preauthorization of the treatment plan is required by Us after You or Your Qualified Practitioner has provided Us with Your diagnosis and treatment plan.

If Preservice Review is necessary for the proposed treatment plans, We will:

1. Advise You if the proposed treatment plan is Medically Necessary; and
2. Advise You if We will continue to review Your Confinement or Services throughout the course of Your Sickness or Bodily Injury.

If Preauthorization is necessary for the proposed treatment plans, We will:

1. Advise You if the proposed treatment plan is a Covered Expense; and
2. Advise You if We will continue to review Your Confinement or Services throughout the course of Your covered Sickness or Bodily Injury.

If Your proposed treatment plan is determined at any time either partially or totally, not to be an eligible Covered Expense under the terms and provisions of this Policy, benefits will only be paid for Services (both Qualified Practitioner and Hospital or Quality Treatment Facility) that are determined to be eligible Covered Expense.

UTILIZATION MANAGEMENT (continued)

If **You** do not notify **Us** prior to an inpatient **Confinement**, non-emergency outpatient **Surgery** or within 48 hours of an emergency admission, benefits will **NOT** be payable for the first \$500 of **Covered Expense**.

The \$500 penalty is **NOT** applied to the **Deductible** or **Out-Of-Pocket Limit** shown on this Schedule of Benefits.

RIGHT TO CONSIDER SUBSTITUTION FOR COVERED EXPENSES

We reserve the right to consider for payment **Expenses Incurred** for **Services** which are substitutions for the **Covered Expenses** of this Policy. The expenses are considered at **Our** option and must:

1. Be **Medically Necessary**;
2. Have **Your** knowledge and agreement while receiving the **Service**;
3. Be prescribed and approved by **Your Qualified Practitioner**; **AND**
4. Offer a medical therapeutic value at least equal to the **Covered Service** that would otherwise be performed or given.

We may disallow a substitute **Service** at any time at **Our** sole option by sending a reasonable advance written notice to **You** and **Your Qualified Practitioner**.

COVERED MEDICAL SERVICES

This section describes Services which will be considered Covered Expense(s). Benefits will be paid for such Covered Medical Services for a Bodily Injury or Sickness on a Maximum Allowable Fee basis and as shown on Your Schedule of Benefits subject to:

1. The Deductible, if applicable;
2. Any Coinsurance percentage; and
3. Up to any maximum benefit.

All other terms, provisions, limitations and exclusions listed in this Certificate are applicable to Covered Medical Services.

HOSPITAL SERVICES

Covered Expense includes charges made by a:

1. Hospital for daily semi-private, ward, intensive care or coronary care room and board charges for each day of Confinement. The maximum amount payable is shown on the Schedule of Benefits. Benefits for a private or single-bed room are limited to the Maximum Allowable Fee charged for a semi-private room in the Hospital while a registered bed patient;
2. Hospital for Services furnished for Your treatment during Confinement;
3. Free-Standing Surgical Facility for Services furnished for Your treatment;
4. Qualified Practitioner, whether billed directly or separately by the Hospital for:
 - A. Professional Services of a radiologist or pathologist for diagnostic x-ray examination or laboratory tests, including x-ray, radon, radium and radioactive isotope therapy; or
 - B. Professional Services of an anesthesiologist;
5. Hospital or Free-Standing Surgical Facility for medical devices surgically implanted in a body cavity to replace or aid the function of an internal organ;
6. Hospital for Outpatient Services when incurred for Preadmission Testing;
7. Hospital for Outpatient Services when incurred for Emergency Care due to a Sickness;
8. Hospital for Outpatient Services when incurred for Emergency Care rendered within 48 hours of an accident;
9. Hospital for Outpatient Services when incurred for a surgical procedure;

COVERED MEDICAL SERVICES (continued)

10. **Hospital** for Outpatient Services when incurred for regularly scheduled treatment such as chemotherapy, inhalation therapy, or radiation therapy as ordered by **Your** attending physician; and
11. **Hospital** for Outpatient Services not to exceed the average semi-private room rate when **You** are in Observation Status.

QUALIFIED PRACTITIONER SERVICES

Covered Expense includes charges made by a:

1. Physician for office, home or inpatient **Hospital** visits;
2. **Qualified Practitioner** for administration of anesthesia;
3. **Qualified Practitioner** for diagnostic x-ray or laboratory tests;
4. **Qualified Practitioner** for a surgical procedure, including post-operative care.

If multiple or bilateral surgical procedures are performed at one operative session, the amount payable for these procedures will be limited to the **Maximum Allowable Fee** for the primary surgical procedure and;

- A. 50% of the **Maximum Allowable Fee** for the secondary procedure; and
- B. 25% of the **Maximum Allowable Fee** for the third and subsequent procedures; and
5. **Qualified Practitioner** for services in performing certain oral surgical operations as follows:
 - A. Excision of partially or completely unerupted impacted teeth;
 - B. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
 - C. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - D. Reduction of fractures and dislocation of the jaw;
 - E. External incision and drainage of cellulitis;
 - F. Incision of accessory sinuses, salivary glands or ducts; and
 - G. Frenectomy (the cutting of the tissue in the midline of the tongue).

COVERED MEDICAL SERVICES (continued)

JAW JOINT BENEFIT (Including TMJ)

Covered Expense incurred by You during a plan of treatment for any jaw joint problem, including temporomandibular joint disorder, craniomaxillary disorder, craniomandibular disorder, head and neck neuromuscular disorder or other conditions of the joint linking the jaw bone and skull, is payable up to \$1,000 during each calendar year for You and each of Your covered Dependents.

The following are Covered Expenses:

1. A single examination including a history, physical examination, muscle testing, range of motion measurements and psychological evaluation, as necessary;
2. Diagnostic x-rays;
3. Physical therapy of necessary frequency and duration, limited to a multiple modality benefit when more than one therapeutic treatment is rendered on the same date of Service;
4. Therapeutic injections;
5. Appliance therapy utilizing an appliance which does not permanently alter tooth position, jaw position or bite. Benefits for reversible appliance therapy will be based on the **Maximum Allowable Fee** for use of a single appliance, regardless of the number of appliances used in treatment. The benefit for the appliance therapy will include an allowance for all jaw relation and position diagnostic Services, office visits, adjustments, training, repair and replacement of the appliance; and
6. Surgical procedures.

Covered Expense does NOT include charges for:

1. CT scans, magnetic resonance imaging except in conjunction with surgical management;
2. Electronic diagnostic modalities;
3. Occlusal analysis;
4. Any irreversible procedure, including, but not limited to: orthodontics, occlusal adjustment, crowns, onlays, fixed or removable partial dentures, full dentures; or
5. Any procedure not specifically listed as a **Covered Expense**.

PRENATAL CARE BENEFIT

Covered Expenses for Prenatal Care are ONLY payable up to the maximum amount as shown on the Schedule of Benefits when:

1. Notification of the pregnancy is received from the female **Covered Person** within one month after diagnosis of the pregnancy;
2. Preauthorization is received from Us.

COVERED MEDICAL SERVICES (continued)

Prenatal Care benefits DO NOT include any charges related to labor, delivery and post-delivery care UNLESS pregnancy is shown as a Covered Expense on the Schedule of Benefits.

PREGNANCY AND NEWBORN SERVICES

Normal pregnancy and well baby charges are Covered Expenses ONLY if shown as a Covered Expense on the Schedule of Benefits.

1. If provided, normal pregnancy charges are a Covered Expense for any female Covered Person. This benefit is payable after the exhaustion of the Prenatal Care Benefit.
2. Complications of Pregnancy are payable as any other covered Sickness at the point the complication occurs for any female Covered Person.
3. Well baby Covered Expense is Expense Incurred by a covered Dependent newborn child during his or her first five days of life for:
 - A. Hospital charges for nursery room, board and care;
 - B. The Qualified Practitioner's charges for circumcision of the newborn child; and
 - C. The Qualified Practitioner's charges for routine examination of the newborn child before release from the Hospital.

Well baby coverage for newborns will be provided ONLY under the following circumstances:

- A. Normal pregnancy benefits are shown as a Covered Expense on the Schedule of Benefits; and
 - B. The mother's delivery charges are a Covered Expense under the Plan.
4. For a covered pregnancy, Hospital Services for Inpatient care provided to the mother and the Dependent newborn child will be covered for:
 - A. A minimum of 48 hours, following a vaginal delivery; or
 - B. A minimum of 96 hours, following a cesarean section;

UNLESS the following applies:

- A. Post-discharge office visit to the physician or in-home nurse visit is provided in the first 48 hours after discharge; or
- B. Earlier discharge is:
 - i) Consistent with the most current version of "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and American College of Obstetricians and Gynecologists; and
 - ii) Consented to by the mother and the attending physician.

COVERED MEDICAL SERVICES (continued)

5. Benefits for sick baby **Covered Expense** is payable for any covered **Dependent** newborn child. Sick baby **Covered Expense** is **Expense Incurred** by a covered **Dependent** newborn child for the following:

- A. Bodily Injury or Sickness;
- B. Medically Necessary care and treatment for premature birth;
- C. Medically diagnosed birth defects and abnormalities; and
- D. Surgery to repair or restore any body part necessary to achieve normal body functioning.

Covered Expense does NOT include **Expense Incurred** for Cosmetic Surgery, EXCEPT Surgery for:

- A. Reconstruction due to **Bodily Injury**, infection or other disease of the involved part; or
- B. Congenital disease or anomaly of a covered **Dependent** child which resulted in a functional defect.

OTHER COVERED EXPENSES

The following are Other Covered Expenses:

- 1. Local professional ambulance service to the nearest **Hospital** equipped to provide the treatment is covered, if the **Bodily Injury** or Sickness requires special treatment not available in a local **Hospital**;
- 2. Blood and blood plasma which is NOT replaced by donation; administration of blood and blood products including blood extracts or derivatives;
- 3. Oxygen and rental of equipment for its administration;
- 4. Initial prosthetic devices or supplies, including but not limited to limbs and eyes. Coverage will be provided for prosthetic devices necessary to restore the minimal basic function of a lost limb or eye. Replacement is a **Covered Expense** if due to pathological changes. **Covered Expense** includes repair of the prosthetic device if not covered by the manufacturer;
- 5. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
- 6. Drugs and medicines that are required by law to be obtained on the written prescription of a **Qualified Practitioner**;
- 7. The rental, up to but not to exceed the purchase price, of a non-motorized wheelchair, hospital bed, ventilator, hospital type equipment or other **Durable Medical Equipment (DME)**. At our option, we may authorize the purchase of **DME** in lieu of its rental if the rental price is projected to exceed the purchase price of the **DME**. Repair or maintenance of the **DME** or duplicate **DME** rentals is not considered a **Covered Expense**;

COVERED MEDICAL SERVICES (continued)

8. The following special supplies, up to a 30-day supply, when prescribed by Your attending physician:
 - A. Surgical dressings;
 - B. Catheters;
 - C. Colostomy bags, rings and belts;
 - D. Flotation pads;
 - E. Needles and syringes; and
 - F. Initial contact lenses or eyeglasses following cataract surgery;

9. Dental treatment only if:

- A. The charges are incurred for treatment for a **Dental Injury** to a **Sound Natural Tooth**;
- B. The **Pre-Existing Condition** Exclusion period, if applicable, has been satisfied;
- C. The treatment begins within 90 days after the date of the injury; and
- D. The treatment is completed within 12 months after the date of the injury.

However, benefits will be paid only for **Expense Incurred** for the least expensive **Service** that will, in **Our** opinion, produce a professionally adequate result.

10. A baseline mammogram for a female **Covered Person** between the ages of 35 and 39 years; an annual mammogram for a female **Covered Person** 40 years of age or older;
11. Routine immunizations for **Covered Persons** under age 18. TB tine and allergy desensitization injections are not considered routine immunizations;
12. For a female **Covered Person**, an annual cervical smear or Pap smear test;
13. For a male **Covered Person**, 40 years of age or older, an annual digital examination and a prostate-specific antigen (PSA) test, when recommended by a **Qualified Practitioner**;
14. Colorectal examinations and laboratory tests for colorectal cancer as prescribed by a physician and in accordance with the American Cancer Society guidelines on colorectal cancer screening or other colorectal cancer screening guidelines issued by nationally recognized professional medical societies or federal government agencies, including the National Cancer Institute, the Centers for Disease Control and Prevention, and the American College of Gastroenterology.
15. For a **Covered Person**, who is receiving benefits in connection with a mastectomy, **Services** for:
 - A. Reconstructive surgery of the breast on which the mastectomy has been performed;
 - B. Surgery and reconstruction of the other breast to achieve symmetrical appearance; and
 - C. Prostheses and physical complications from all stages of mastectomy, including lymphedemas;

COVERED MEDICAL SERVICES (continued)

16. Following a mastectomy, **Medically Necessary** length of stay for inpatient care and post-discharge office visit to the physician or in home nurse visit provided in the first 48 hours after discharge.

For the purposes of this provision, "mastectomy" means the removal of all or a part of the breast for medically necessary reasons, as determined by a licensed physician;
17. Any Drug approved by the Federal Food and Drug Administration (FDA) and used in the treatment of neoplasm, regardless of whether the drug was approved by FDA for the treatment of the specific neoplasm for which the drug is being used, if all the following conditions are met:
 - A. The drug is ordered by a physician for the treatment of a specific type of neoplasm;
 - B. The drug is approved by the Federal Food and Drug Administration for use in anti-neoplastic therapy;
 - C. The drug is used as part of an anti-neoplastic drug regimen;
 - D. Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment; and
 - E. The physician has obtained informed consent from the patient for the treatment regimen which includes Federal Food and Drug Administration approved drugs for off-label indications; and
18. Patient care costs for blood tests, x-rays, bone scans, magnetic resonance images, patient visits, hospital stays, or other similar costs generally incurred in standard cancer treatment for a **Covered Person** who is:
 - A. Diagnosed with a terminal condition related to cancer; and
 - B. Is participating in an approved cancer research trial in Phase II, Phase III or Phase IV of investigation.
19. **Hospital or Free-Standing Surgical Facility Services** and anesthesia charges associated with dental procedures for the following **Covered Persons**:
 - A. A child age six or under;
 - B. An individual who has a medical condition that requires hospitalization or general anesthesia for dental care;
 - C. An individual who is disabled.
20. If **Medically Necessary**, coverage for bone mass measurement and treatment for osteoporosis.

PHYSICAL MEDICINE BENEFIT

Covered Expense for outpatient Physical Medicine is payable to a maximum benefit amount as shown on the Schedule of Benefits. Physical Medicine expenses include charges incurred during the diagnosis and treatment of physical conditions relating to bone, muscle or neuromuscular pathology, including but not limited to, speech, physical, occupational, growth and cognitive therapies; biofeedback; rolfing; adjustments and manipulations of any spinal or bodily area; and cardiac exercise programs.

COVERED MEDICAL SERVICES (continued)

Treatment of cerebral vascular accidents (CVA), burns, fractures or related conditions for which **You** are hospitalized or had **Surgery** and when **Physical Medicine** immediately follows discharge, is payable as any other **Sickness** or **Bodily Injury** and is not limited to the **Physical Medicine Benefit**.

SKILLED NURSING FACILITY BENEFIT

Covered Expense for daily room and board and general nursing services for each day of **Confinement** in a **Skilled Nursing Facility** is payable for up to 30 days during each calendar year when **Preauthorization** is received from **Us**.

A **Skilled Nursing Facility Confinement** means only a **Confinement** in a **Skilled Nursing Facility** which occurs when **You** are under the regular care of a **Qualified Practitioner** who has reviewed and approved the **Confinement**.

Preauthorization is required by **Us**. If **Preauthorization** is not received from **Us**, **NO** benefits will be payable under this Policy for **Skilled Nursing Facility** care.

HOME HEALTH CARE BENEFIT

Covered Expense for Home Health Care as described below is payable under this Policy. A **Home Health Care Provider** must render **Services** at **Your** home under a **Home Health Care Plan**, as described below. The **Home Health Care Plan** must begin within 14 days after discharge from a **Hospital**, **Qualified Treatment Facility** or **Skilled Nursing Facility**, unless waived by **Us**. Nothing in this provision will increase benefits to cover Home Health Care **Services** which are not otherwise covered under this Policy.

The maximum benefit per **Covered Person** is 100 **Home Health Care Visits** per calendar year as shown on **Your** Schedule of Benefits.

Covered Expense is only payable when:

1. **Preauthorization** is received from **Us**; and
2. **Home Health Care** is in lieu of a covered **Confinement** in a **Hospital**, **Qualified Treatment Facility** or **Skilled Nursing Facility**

If the above criteria are not met, **NO** benefits will be payable under this Policy for Home Health Care.

Home Health Care benefits do **NOT** include:

1. Charges for mileage or travel time to and from the **Covered Person's** home;
2. Wage or shift differentials for **Home Health Care Providers**; or
3. Charges for supervision of **Home Health Care Providers**.

COVERED MEDICAL SERVICES (continued)

HOSPICE CARE BENEFIT

Covered Expense for Hospice Care as described below is payable under this Policy. Benefits for a **Hospice Care Program** must be furnished in a **Hospice Facility** or in **Your home** by a **Hospice Care Agency**. A physician must certify that **You** are terminally ill with a life expectancy of six months or less. For this benefit only, **Your immediate family** is considered to be **Your parent, spouse and Your children or step-children**.

Covered Expense is only payable when:

1. **Preauthorization** is received from Us; and
2. Hospice Care is in lieu of a **Confinement** in a **Hospital** or **Skilled Nursing Facility**.

If the above criteria are not met, NO benefits will be payable under this Policy for Hospice Care.

Hospice Care benefits are payable as shown on the Schedule of Benefits for the following hospice Services, subject to the Policy Lifetime Maximum benefit:

1. Room and board;
2. Other Services;
3. Part-time nursing care provided by or supervised by an R.N. for up to eight hours per day;
4. Counseling by a licensed:
 - A. Clinical social worker; or
 - B. Pastoral counselor for the **Hospice Patient** and the immediate family. This counseling is limited to a total of 15 visits per family;
5. Medical social services provided to **You** or **Your immediate family** under the direction of a **Qualified Practitioner**, up to a maximum benefit of \$100, including:
 - A. Assessment of social, emotional and medical needs, and the home and family situation; and
 - B. Identification of the community resources available;
6. Psychological and dietary counseling;
7. Physical therapy;
8. Part-time home health aide Services for up to eight hours in any one day; and
9. Medical supplies, drugs and medicines prescribed by a **Qualified Practitioner**.

COVERED MEDICAL SERVICES (continued)

HOSPICE CARE BENEFITS DO NOT INCLUDE:

1. Private duty nursing when confined in a **Hospice Facility**;
2. A **Confinement** not required for pain control or other acute chronic symptom management;
3. Funeral arrangements;
4. Financial or legal counseling, including estate planning or drafting of a will;
5. Homemaker or caretaker **Services**, including:
 - A. Sitter or companion **Services**;
 - B. Housecleaning;
 - C. Household maintenance;
6. **Services** of a social worker other than a licensed clinical social worker;
7. **Services** by volunteers or persons who do not regularly charge for their **Services**;
8. **Services** by a licensed pastoral counselor to a member of his or her congregation. These are **Services** in the course of the duties to which he or she is called as a pastor or minister; and
9. Bereavement counseling **Services**.

COVERED SERVICES-MENTAL HEALTH

INCLUDES MENTAL DISORDERS AND SUBSTANCE ABUSE

Limited benefits are payable for Covered Expense incurred for the treatment of Mental Disorders, and chemical and alcohol dependence.

Covered Expense includes:

1. Charges made by a Qualified Practitioner;
2. Charges made by a Hospital; and
3. Charges made by a Qualified Treatment Facility.

Substance Abuse:

Substance abuse means that term as defined in Section 6107 of Act. No. 368 of the Public Acts of 1978, being Section 333.6107 of the Michigan Compiled Laws, for chemical and alcohol dependence.

Intermediate Care means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

1. Chemotherapy;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

Outpatient Care means the use, on both a scheduled and non-scheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

1. Chemotherapy;
2. Counseling;
3. Detoxification services; or
4. Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in a treatment plan.

COVERED SERVICES-MENTAL HEALTH (continued)

The Calendar Year Maximum Benefit for Covered Expenses for treatment of Substance Abuse for each Covered Person is adjusted annually by March 31 each year in accordance with the annual average percentage increase or decrease in the United States consumer price index (C.P.I.) for the 12-month period ending the preceding December 31. Contact Us for the current calendar year maximum benefit payable by the Policy.

BENEFITS FOR MENTAL DISORDERS AND SUBSTANCE ABUSE ARE PAYABLE AS SHOWN ON YOUR SCHEDULE OF BENEFITS.

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS

The Policy does NOT provide benefits for:

1. **Services not Medically Necessary** for diagnosis and treatment of a **Bodily Injury** or **Sickness**;
2. Any **Service** which is **Experimental**, **Investigational**, or for **Research Purposes**, unless otherwise indicated in this Certificate;
3. **Services**:
 - A. Not furnished by a **Qualified Practitioner** or **Qualified Treatment Facility**;
 - B. Not authorized or prescribed by a **Qualified Practitioner**;
 - C. For which no charge is made, or for which **You** would not be required to pay if **You** did not have this insurance, unless charges are received from and reimbursable to the **United States Government** or any of its agencies as required by law;
 - D. Furnished by or payable under any plan or law through a **Government** or any political subdivision, unless prohibited by law;
 - E. Furnished while **You** are confined in a **Hospital** or institution owned or operated by the **United States Government** or any of its agencies for any service-connected **Sickness** or **Bodily Injury**;
 - F. Which are not rendered;
 - G. That are not listed as **Covered Expense**;
 - H. Provided by a person who ordinarily resides in **Your** home or who is a **Family Member**;
 - I. Any **Hospital**, ancillary or other **Service** performed in association with a **Service** that is not covered under this plan;
 - J. That are billed separately as professional **Services**, when the procedure requires only a technical component (CPT code) that gives a numerical or self-explanatory result and does not require professional intervention or interpretation; or
 - K. That are billed incorrectly or billed separately, but are an integral part of another billed **Service**, as determined by Us;
4. Any drug, medicine, or device which does not have the **United States Food and Drug Administration** formal market approval through a **New Drug Application**, **Premarket Approval**, or **510K**;
5. Charges in excess of the **Maximum Allowable Fee** for the **Service**;
6. **Pre-Existing Conditions** to the extent specified in this Certificate and on the **Schedule of Benefits**;
7. **Custodial Care** and **Maintenance Care**;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS
(continued)

8. **Cosmetic Surgery** or any complication therefrom, unless for **Reconstructive Surgery**:
- A. Resulting from:
- i) A **Bodily Injury**, infection or other disease of the involved part; or
- ii) Congenital disease or anomaly of a covered **Dependent** child which resulted in a functional defect; or
- B. For a **Covered Person**, who is receiving benefits in connection with a mastectomy for:
- i) **Reconstructive Surgery** of the breast on which the mastectomy has been performed; and
- ii) **Surgery** and reconstruction of the other breast to achieve symmetrical appearance.
9. Any artificial means to achieve pregnancy or ovulation, including but not limited to, artificial insemination, in vitro fertilization, spermatogenesis, GIFT, ZIFT, tubal ovum transfer, embryo freezing or transfer, sperm banking, and all related fertility testing and treatment;
10. Elective abortions, reversal of sterilizations, or medical care or **Surgery** to change gender;
11. Treatment of normal pregnancy and well baby expenses, unless provided on the Schedule of Benefits;
12. Any **Expense Incurred** after the date **Your** coverage under this Policy terminates;
13. Eye refractive disorders, eyeglass frames and lenses or contact lenses, or radial keratotomy and any other **Surgery** to correct myopia, hyperopia or stigmatic error, vision therapy, orthoptic treatment (eye exercises), unless specifically described in this Certificate;
14. Routine physical, hearing, or eye exams:
- A. For occupation, employment, school, travel, the purchase of insurance, or premarital tests or examinations;
- B. For health checkups, unless otherwise indicated in this Certificate;
15. **Sickness** or **Bodily Injury** for which there is medical payment or expense coverage provided or payable under any automobile, homeowners, premises, or any other similar coverage. Payments made by any other coverage will be credited toward any applicable calendar year **Deductible** and **Coinurance** for the year the **Sickness** or **Bodily Injury** was initially sustained;
16. **Dental Services**, appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes, including but not limited to, any oral or periodontal **Surgery** and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental **Services** related to a **Bodily Injury** or **Sickness** unless otherwise indicated in this Certificate;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS
(continued)

17. Any loss contributed to or caused by:
 - A. War or any act of war, whether declared or not; or
 - B. Any act of armed conflict, or any conflict involving armed forces of any authority;
18. The treatment of **Mental Disorders**, chemical or alcohol dependence unless specifically provided in the Mental Health Covered Services provision of this Certificate and shown on **Your** Schedule of Benefits;
19. Private duty nursing while confined in a **Hospital, Qualified Treatment Facility** or other institution;
20. Loss due to commission or attempt to commit a civil or criminal battery or felony;
21. Any charges, including **Qualified Practitioner** charges, which are incurred if **You** are admitted to a **Hospital** on a Friday or Saturday unless;
 - A. **Your Hospital** admission is due to **Emergency Care**; or
 - B. Treatment or Surgery is performed on that same day;
22. **Services** rendered by a standby physician or assistant surgeon unless **Medically Necessary**;
23. Therapy and testing for treatment of allergies, including but not limited to **Services** related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and/or treatment UNLESS such therapy or testing is approved by:
 - A. The American Academy of Allergy and Immunology, or
 - B. The Department of Health and Human Services or any of its offices or agencies;
24. Any treatment to reduce obesity including, but not limited to, surgical procedures;
25. Treatment of nicotine habit or addiction, including but not limited to nicotine patches, hypnosis, smoking cessation classes or tapes;
26. Vitamins, dietaries, and any other non-prescription supplements;
27. Educational or vocational therapy, **Services** and schools, including but not limited to videos and books;
28. Treatment of weak, strained, flat, unstable or unbalanced feet, arch supports, heel wedges, lifts, orthopedic shoes, or the fitting of orthotics to aid walking or running;
29. Communications, lodging accommodations, and transportation or travel time;

MEDICAL BENEFITS - LIMITATIONS AND EXCLUSIONS (continued)

30. Charges for Services that are primarily and customarily used for a nonmedical purpose or used for environmental control or enhancement (whether or not prescribed by a physician) including but not limited to air conditioners, air purifiers, vacuum cleaners, motorized transportation equipment, escalators, elevators, ramps, waterbeds, hypoallergenic mattresses, cervical pillows, swimming pools, whirlpools, spas, exercise equipment, gravity lumbar reduction chairs, home blood pressure kits, personal computers and related equipment or other similar items or equipment;
31. Hearing aids, hair prosthesis, hair transplants or implants, and wigs;
32. Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs;
33. Medications, drugs or hormones to stimulate growth unless there is a laboratory confirmed diagnosis of growth hormone deficiency;
34. Sleep therapy or Services rendered in a premenstrual syndrome clinic, or holistic medicine clinic;
35. Prescription drugs dispensed at any given time in excess of a 30-day supply;
36. Inpatient Hospital Services when You are in Observation Status;
37. Massage therapy;
38. Immunizations required for foreign travel for Covered Persons of any age;
39. Treatment of any Bodily Injury or Sickness that is sustained by an Employee or a covered Dependent that arises out of, or as the result of, any work for wage or profit when coverage under any Workers' Compensation Act or similar law is required for the Employee or covered Dependent.

This exclusion does not apply to the following Employees of the Employer that are or may be eligible for coverage under any Workers' Compensation Act or similar law when the Employer is given the option to apply for such coverage by such Act or law and the Employer did not apply for such coverage; provided 24-hour medical coverage was selected by the Employer on the Group Application, and which application was approved by Us, and the required additional premium was paid to us:

- A. Sole proprietor, if the Employer is a proprietorship;
- B. A partner of the Employer, if the Employer is a partnership;
- C. An executive officer of the Employer, if the Employer is a corporation.

COORDINATION OF BENEFITS

If You are covered under any plans defined below, Covered Expense You incur under this Plan will be coordinated with benefits payable under the other Plans defined below.

BENEFITS SUBJECT TO THIS PROVISION

Medical benefits described in this Certificate are coordinated with medical and dental benefits provided by other group insurance plans under which You are also covered. This is to prevent the problem of overinsurance and a resulting increase in the cost of medical coverage.

DEFINITIONS

1. PLAN

For this purpose a Plan is one which covers medical or dental expenses and provides benefits or service through:

- A. Group insurance coverage;
- B. Hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice or other prepayment coverage on a group basis; and
- C. Any coverage under labor-management plan, employer plans, trustee plans, union welfare plans, employee benefit organization plans.

Employers' Plans under the same Trust Policy are considered separate Plans.

This Coordination of Benefits provision does NOT apply to Blanket Student Accident Insurance provided by or through an educational institution. Any coverage under governmental programs, or any coverage mandated by state statute, or sponsored or provided by an educational institution, will be appropriately coordinated if such coverage is not otherwise excluded from the calculation of benefits under this Policy. The term "Plan" does not apply to any individual policies.

The term "Plan" is construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

2. ALLOWABLE EXPENSE

Allowable Expense means any necessary, reasonable and customary item of expense at least a portion of which is covered under at least one of the Plan(s) covering the person for whom claim is made.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered as both an Allowable Expense and a benefit paid.

COORDINATION OF BENEFITS (continued)

3. CLAIM DETERMINATION PERIOD

Claim Determination Period means calendar year, except that if in any calendar year the person is not covered under this Policy for the full calendar year, the Claim Determination Period for that year will be that portion during which he or she was covered under this Policy.

EFFECT ON BENEFITS

We will apply these provisions when You incur Allowable Expenses during a Claim Determination Period for which benefits are payable under any other Plan(s). The provisions will apply only when the sum of the Covered Expense under this Policy and any other Plan(s) would, in the absence of these Coordination of Benefits provisions or any similar provisions in the other Plan(s), exceed the Allowable Expenses.

Benefits provided under this Policy during a Claim Determination Period for Allowable Expenses incurred by You will be determined as follows:

1. If benefits under this Policy are to be paid after benefits are paid under any other Plan, the benefits under this Policy will be reduced so that the sum of the benefits so reduced plus the benefits payable under all other Plans will not exceed the total of the Allowable Expenses.
2. If benefits under this Policy are to be paid before benefits are paid under any other Plan, benefits under this Policy will be paid without regard to other Plan(s).

Covered Expense under any other Plan includes the benefits that would have been payable had claim been made.

Under no circumstances will Your reimbursement exceed 100% of the total Allowable Expenses incurred under this Policy and any other Plans included under this provision.

ORDER OF BENEFITS DETERMINATION

For the purpose of the Effect on Benefits provision above, the rules establishing the Order of Benefits Determination are:

1. The benefits of a Plan which covers the person on whose expenses claim is based other than as a **Dependent** are determined before the benefits of a Plan which covers such person as a **Dependent**.
2. The benefits of a Plan which covers the person on whose expenses claim is based as a **Dependent** are determined according to which parent's birthdate occurs first in a calendar year, excluding year of birth. If the birthdates of both parents are the same, the Plan which has covered the person for the longer period of time will be determined first, except if a claim is made for a **Dependent** child:
 - A. When parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a **Dependent** of a parent with custody of the child are determined before the benefits of a Plan which covers the child as a **Dependent** of the parent without custody.

COORDINATION OF BENEFITS (continued)

- B. When parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a **Dependent** of the parent with custody are determined before the benefits of a Plan which covers that child as a **Dependent** of the step-parent, and the benefits of a Plan which covers that child as a **Dependent** of the step-parent are determined before the benefits of a Plan which covers that child as a **Dependent** of the parent without custody.
- C. Notwithstanding provisions "A" and "B," if there is a court decree which should otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to a child, the benefits of a Plan which covers the child as a **Dependent** of the parent with such financial responsibility are determined before the benefits of any other Plan which covers the child as a **Dependent** child.
- 3. When rules 1. and 2. do not establish an Order of Benefits Determination, the benefits of a Plan which covers the person on whose expense claim is based as a laid-off or retired **Employee** or as the **Dependent** of such person are determined after the benefits of a Plan which covers such person through present employment.
- 4. When rules 1., 2. and 3. do not establish an Order of Benefits Determination, the benefits of a Plan which has covered the person on whose expense claim is based for the longer period of time are determined before the benefits of a Plan which has covered such person the shorter period of time.
- 5. If the provisions under the other Plan determining the effect of its Coordination of Benefits provision or exclusion are irreconcilable with the above rules, this Policy will waive application of the above rules and incorporate the rules identical with those of the other Plan.

When these provisions reduce the total amount of benefits otherwise payable to **You** under this Policy during any Claim Determination Period, each benefit that would be payable in the absence of this provision is reduced proportionately and such reduced amounts are charged against any applicable benefit limit of this Policy.

RIGHT TO NECESSARY INFORMATION

We may require certain information in order to apply and coordinate these provisions with other Plans. To obtain the needed information, **We**, without **Your** consent, will release or obtain from any insurance company, organization or person information needed to implement this provision. **You** agree to furnish any information **We** need to apply these provisions.

COORDINATION OF BENEFITS WITH MEDICARE

In all cases, Coordination of Benefits with Medicare will conform with Federal Statutes and Regulations.

If **You** are eligible for Medicare benefits, but not necessarily enrolled, **Your** benefits under this Policy will be coordinated to the extent benefits otherwise would have been payable under Medicare as allowed by Federal Statutes and Regulations.

Medicare means Title XVIII, Parts A and B of the Social Security Act, as enacted or amended.

COORDINATION OF BENEFITS (continued)

FACILITY OF PAYMENT

Payments made under any other Plan which according to these provisions should have been made by Us, will be adjusted by Us. To do this, We reserve the sole right to pay the organization(s) which made such payments the amount(s) the Company determines to be warranted. Any amount(s) so paid are regarded as benefits paid under this Policy. We will be fully discharged from liability under this Policy to the extent of any payment so made.

RIGHT OF RECOVERY

We reserve the right to recover benefit payments made for Allowable Expenses under this Policy in the amount by which the payments exceed the maximum amount We are required to pay under these provisions. This Right of Recovery applies to Us against:

1. Any person(s) to, for or with respect to whom such payments were made; or
2. Any other insurance companies or organizations which according to these provisions owe benefits for the same Allowable Expense under any other Plan.

We alone shall determine against whom this Right of Recovery will be exercised.

EXTENDED BENEFITS

If You are **Totally Disabled** as a result of a covered **Bodily Injury** or **Sickness** existing on the date You terminate coverage under the Employer's group medical insurance plan, We will continue to provide medical benefits for the disabling condition until the earliest of the following:

1. The date **Your Qualified Practitioner** certifies You are no longer **Totally Disabled**;
2. The date You receive benefits equal to any maximum benefit shown on the Schedule of Benefits;
3. The end of 12 consecutive months immediately following the date Your coverage terminated. The 12 month period begins on the day Your coverage terminated and ends 12 months later on the same calendar day.

The termination of **Your Employer's** participation under this Policy will NOT terminate Extended Benefits.

The Extended Benefits provision applies only to **Covered Expenses** for the disabling condition which existed on the date **Your** coverage terminated.

REPLACEMENT

ENTIRE GROUP REPLACEMENT

APPLICABILITY

The Replacement provision applies when the Employer's previous group medical insurance plan is terminated and replaced within 90 days by coverage under this Policy and:

1. You are eligible to become insured for medical coverage on the effective date of the Employer's participation under this Policy; and
2. You were validly covered under the Employer's previous employer based medical plan (Prior Plan) on the day before the effective date of the Employer's participation under this Policy.

Benefits are NOT payable under this Policy for medical expense due to any Bodily Injury or Sickness for which You are entitled to receive benefits during any extension period provided by the Prior Plan.

DELAYED EFFECTIVE DATE

If any Delayed Effective Date provision described in this Certificate applies to You on the date You are otherwise eligible to become insured under this Policy, We will waive that provision. Medical coverage as set forth in this Certificate is then provided to You until the earlier of the following dates:

1. The last day of the 12 consecutive month period following the effective date of the Employer's participation under this Policy; or
2. The date Your medical coverage would otherwise terminate according to the TERMINATION OF COVERAGE provision stated in this Certificate.

If the Delayed Effective Date provision ceases to apply to You before 1. or 2. above occurs, Your medical coverage will continue without break.

DEDUCTIBLE/COINSURANCE AMOUNT

Medical Expense Incurred while You were covered under the Prior plan may be used to satisfy Your deductible/coinsurance amount under this Policy if:

1. The Expense Incurred was applied to the deductible/coinsurance amount under the Prior Plan during the ninety days preceding the effective date of this Policy; and
2. The Expense Incurred qualifies as a Covered Expense under this Policy; and
3. The Expense Incurred would have served to partially or fully satisfy the deductible/coinsurance amount under this Policy for the calendar year in which Your coverage becomes effective.

REPLACEMENT (continued)

PRE-EXISTING CONDITIONS

If a **Bodily Injury** or **Sickness** is a **Pre-Existing Condition** as stated on the Schedule of Benefits but would not have been a **Pre-Existing Condition** under the Prior Plan had it remained in force, it will not be a **Pre-Existing Condition** under this Policy.

If a **Bodily Injury** or **Sickness** is a **Pre-Existing Condition** under both the Prior Plan and this Policy, any benefits payable are applicable only to medical expenses which were incurred after the date such **Bodily Injury** or **Sickness** would no longer have been a **Pre-Existing Condition** under the Prior Plan had it remained in force.

The amount payable for such **Bodily Injury** or **Sickness** will be the lesser of:

1. The benefits payable under this Policy regardless of any **Pre-Existing Condition Limitation**; or
2. The benefits that would have been payable under the Prior Plan had it remained in force reduced by any amount actually paid by the Prior Plan for such **Bodily Injury** or **Sickness**.

However, this does NOT apply to any **Bodily Injury** or **Sickness** for which **You** are entitled to receive benefits during any extension period provided by the Prior Plan.

GENERAL PROVISIONS

NOTICE OF CLAIM

NOTICE OF CLAIM

Written notice of claim, other than claim for loss of life, must be given within 30 days after the date of loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice must be given at Our address shown on **Your** identification card. Notice should include **Your** name and the name(s) of **Your** Dependent(s) and **Your** Group Number.

Written notice of claim for loss of life must be furnished to Us within 12 months after the date of death. If a death claim is filed later, We must have proof that it was not possible for the claim to be filed within 12 months.

CLAIM FORMS

Upon receipt of notice of claim, We will send **You** the forms for filing proof of loss. If the forms are not sent to **You** within 15 days, **You** will have met the proof of loss requirement by sending Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss provision.

PROOF OF LOSS

You must give written proof of loss within 90 days after the date of loss, except for loss of life. **Your** claim will not be reduced or denied if it was not reasonably possible to give such proof. In any event, written notice must be given within one year after the date proof of loss is otherwise required, except if **You** were legally incapacitated.

TIME OF PAYMENT OF CLAIMS

Payments due under this Policy will be paid upon receipt of written proof of loss.

CLAIM APPEAL PROCEDURE

If We partially or fully deny a claim for benefits submitted by **You**, and **You** disagree or do not understand the reasons for this denial, **You** may appeal this decision. **You** have the right to:

1. Request a review of the denial;
2. Review pertinent plan documents; and

GENERAL PROVISIONS (continued)

3. Submit in writing, any data, documents or comments which are relevant to Our review of this denial.

Your appeal must be submitted in writing within 60 days of receiving written notice of denial. We will review all information and send written notification within 60 days of Your request.

INCONTESTABILITY

After You are insured without interruption for two years, We cannot contest the validity of Your coverage except for:

1. Nonpayment of premium;
2. Your ineligibility under the Policy;
3. Any Policy provision;
4. Any fraudulent misrepresentation made by You; or
5. Any defenses We may have by law.

No statement made by You can be contested unless it is in a written form signed by You. A copy of the form must be given to You or Your beneficiary.

An independent incontestability period begins for each type of change in coverage or when We require a new Employee Enrollment Form.

This provision only limits Our right to void Your coverage after You have been insured without interruption for two years.

FRAUD

If You commit fraud against Us or Your Employer commits fraud pertaining to You against Us as determined by a court of competent jurisdiction, Your coverage ends automatically, without notice.

TIME LIMIT ON CERTAIN DEFENSES

A claim will not be reduced or denied after two years from the effective date of the benefit because a disease or physical condition not excluded and causing the loss existed before the benefit effective date.

CLERICAL ERROR, MISSTATEMENT OF AGE OR GENDER

If it is determined that information about the age or gender of You or Your Dependents was omitted or misstated in error, the amount of insurance for which You are properly eligible will be in effect. An equitable premium adjustment will be made. This provision applies equally to You and to Us. If the error was determined after six months from the effective date of Your coverage, no adjustment will be made.

GENERAL PROVISIONS (continued)

DUPLICATING PROVISIONS

If any charge is described as covered under two or more benefit provisions, We will pay only under the provision allowing the greater benefit. This may require Us to make a recalculation based upon both the amounts already paid and the amounts due to be paid. We have NO liability for benefits other than those this Policy provides.

WORKERS' COMPENSATION NOT AFFECTED

This Policy is not issued in lieu of, nor does it affect any requirement for coverage by any Worker's Compensation or Occupational Disease Act or Law.

PAYMENT OF CLAIMS

We may pay all or a portion of any benefit provided for health care Services to the provider unless You direct otherwise in writing by the time the proof of loss is filed.

Benefits accrued on behalf of You or Your covered Dependent upon death will be paid, at Our option, to any one or more of the following:

1. Your spouse;
2. Your Dependent children, including legally adopted children;
3. Your parents;
4. Your brothers and sisters; or
5. Your estate.

We will rely upon an affidavit to determine benefit payment, unless We receive written notice of valid claim before payment is made. The affidavit will release Us from further liability.

Any payment made by Us in good faith will fully discharge Us to the extent of such payment.

RIGHT TO REQUEST OVERPAYMENTS

We reserve the right to recover any payments made by Us that were made in error.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with Us and when asked, assist Us by:

1. Authorizing the release of medical information including the names of all providers from whom You received medical attention;
2. Obtaining medical information and/or records from any provider as requested by Us;

GENERAL PROVISIONS (continued)

3. Providing information regarding the circumstances of **Your** injury or accident;
4. Providing information about other insurance coverage and benefits; and
5. Providing information **We** request to administer this Policy.

PHYSICAL EXAMINATION AND AUTOPSY

We, at **Our** expense, have the right to have **You** examined as often as **We** deem reasonably necessary. **We** may also have an autopsy performed unless prohibited by law.

LEGAL ACTIONS

You cannot bring an action at law or equity to recover a claim until 60 days after the date written proof of loss is made. **You** cannot bring such action more than three years after such proof of loss is made.

ASSIGNMENT OF BENEFITS

Assignment of Benefits may be made only with **Our** consent. An assignment is not binding until **We** receive and acknowledge in writing the original or copy of the assignment before payment of the benefit. **We** do not guarantee the legal validity or effect of such assignment.

WORKER'S COMPENSATION

If benefits are paid by **Us** and **We** determine **You** received Workers' Compensation for the same incident, **We** have the right to recover as described under the "Recovery Rights" provision. **We** will exercise **Our** right to recover against **You**.

The Recovery Rights will be applied even though:

1. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise;
2. NO final determination is made that **Bodily Injury** or **Sickness** was sustained in the course of or resulted from **Your** employment;
3. The amount of Workers' Compensation due to medical or health care is not agreed upon or defined by **You** or the Workers' Compensation carrier; or
4. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

You hereby agree that, in consideration for the coverage provided by this Policy, **You** will notify **Us** of any Workers' Compensation claim **You** make, and that **You** agree to reimburse **Us** as described above.

GENERAL PROVISIONS (continued)

MODIFICATION OF POLICY

This Policy may be modified at any time by agreement between Us and the Policyholder without the consent of any participating Employer or any Covered Person or any beneficiary. No modification will be valid unless approved by Our President or Secretary. The approval must be endorsed on or attached to this Policy. No agent has authority to modify this Policy, or waive any of the Policy provisions, to extend the time of premium payment, or bind Us by making any promise or representation.

PREMIUM CONTRIBUTIONS

Your Employer must pay the required premiums to Us as they become due. Your Employer may require You to contribute toward the cost of Your insurance. Failure of Your Employer to pay any required premium to Us on time will result in the termination of Your insurance.

GRACE PERIOD

A grace period of 31 days will be allowed for payment of each premium due. If premium due is not paid within the grace period, We will cancel the insurance at the end of the grace period. All due and unpaid premium, including premium for the grace period, must be paid to Us by Your Employer.

AUDIT OF BILL

We want You to carefully review Your medical bills.

If You find any error such as:

1. Treatment billed but not received;
2. Incorrect arithmetic; or
3. Other Services not received,

and the error results in an overcharge, You should send Us a copy of the bill with the error noted and the corrected bill as proof that the providers of Service agree to the revised charges. If You are correct, We will pay You 50% of Our savings, up to a maximum of \$1,000.

The provision DOES NOT apply to duplicate billings.

RECOVERY RIGHTS

RIGHT OF SUBROGATION

If, after payments have been made under this Policy, You or Your covered Dependents has a right to recover damages from a responsible party, We will be subrogated to Your rights to recover. You or Your covered Dependent will do whatever is necessary to enable Us to exercise Our right and will do nothing after loss to prejudice it. If We are precluded from exercising Our Right of Subrogation, We may exercise Our Right of Reimbursement.

GENERAL PROVISIONS (continued)

RIGHT OF REIMBURSEMENT

If benefits are paid under this Policy and You or Your covered Dependent recovers from a responsible party by settlement, judgment or otherwise, We have a right to recover from You or Your covered Dependent an amount equal to the amount We paid.

ASSIGNMENT OF RECOVERY RIGHTS

This Policy contains an exclusion for Sickness or Bodily Injury for which there is Medical Payment/Expense coverage provided or payable under any automobile, homeowner's, premises or other similar coverage.

If Your claim against the other insurer is denied or partially paid, We will process Your claim according to the terms and conditions of this Policy. If payment is made by Us on Your behalf, You agree to assign to Us any right You have against the other insurer for medical expenses We pay.

SHARED SAVINGS PROGRAM

As a member of a Preferred Provider Organization Plan, You are free to obtain Services from providers participating in the Preferred Provider Organization network (Preferred Providers), or providers not participating in the Preferred Provider Organization network (Non-Preferred Providers). If You choose a Preferred Provider, Your out-of-pocket expenses are normally lower than if You choose a Non-Preferred Provider.

We have a Shared Savings Program that may allow You to share in discounts We have obtained from Non-Preferred Providers.

Although Our goal is to obtain discounts whenever possible, We cannot guarantee that Services rendered outside the Preferred Provider Organization network will be discounted. The Non-Preferred Provider discounts in the Shared Savings Program may not be as favorable as Preferred Provider discounts.

In most cases, to maximize Your benefit design and minimize Your out-of-pocket expense, please access Your Preferred Provider Organization network of providers associated with Your Plan.

If You choose to obtain Services from a Non-Preferred Provider, it is not necessary for You to inquire about a provider's status in advance. When processing Your claim, We will automatically determine if that provider is participating in the Shared Savings Program and calculate Your Deductible and Coinsurance on the discounted amount. Your Explanation of Benefits statement will reflect any savings with a remark code used to reference the Shared Savings Program.

However, if You would like to inquire in advance to determine if a Non-Preferred Provider participates in the Shared Savings Program, please call 1-800-558-4444. Please note, provider arrangements in the Shared Savings Program are subject to change without notice. We cannot guarantee that the provider from whom You received treatment is still participating in the Shared Savings Program at the time treatment is received. Discounts are dependent upon availability and cannot be guaranteed.

We reserve the right to modify, amend, or discontinue the Shared Savings Program at any time.

DISCOUNT DISCLOSURE

From time to time, We may offer or provide access to discount programs to persons who become insureds. In addition, We may arrange for third party service providers such as pharmacies, optometrists, dentists and alternative medicine providers, to provide discounts on goods and services to persons who become insureds. Some of these third party service providers may make payments to Us when insureds take advantage of these discount programs. These payments offset the cost to Us of making these programs available and may help reduce the costs of Your plan administration. Although We have arranged for third parties to offer discounts on these goods and services, these discount programs are not insured benefits under this Policy. The third party service providers are solely responsible to insureds for the provision of any such goods and/or services. We are not responsible for any such goods and/or services, nor are We liable if vendors refuse to honor such discounts. Further, We are not liable to insureds for the negligent provision of such goods and/or services by third party service providers. Discount programs may not be available to persons who "opt out" of marketing communications and where otherwise restricted by law.

SUPPLEMENTAL BENEFIT PRESCRIPTION DRUG BENEFIT

This benefit Rider is attached to and made a part of **Your Certificate**. The effective date of this change is the latter of the effective date of the Certificate or the date this benefit is added to the Policy. Except as modified below, all Policy terms, conditions and limitations apply.

Notwithstanding any other provisions of the Policy to the contrary, this rider amends the Certificate to remove the benefits for coverage of Prescription drugs, medicines, or medications dispensed by a Pharmacy. Prescription drug expenses covered under this Rider are not covered under any other provision of the Policy. Any amount in excess of the maximum amount provided under this rider, if any, is not covered under any other provision in the Policy.

PRESCRIPTION DRUG COST SHARING

You are responsible for payment of the per Prescription Co-Payment.

When the **Covered Person** requests a Brand-Name Medication when a Generic Medication is available, the **Covered Person** is responsible for the applicable Generic Medication Co-Payment and 100% of the difference between the amount **We** would have paid the dispensing **Pharmacy** for the Brand-Name Medication and the amount **We** would have paid the dispensing **Pharmacy** for the Generic Medication, unless the prescribing **Qualified Practitioner** determines that the Brand-Name Medication is **Medically Necessary**, then the **Covered Person** will only be responsible for the applicable Co-Payment for a Brand-Name Medication on **Our Drug List**.

Any **Expenses Incurred** under provisions of this Rider do not apply toward the **Covered Person's Out-of-Pocket Limits**.

SCHEDULE OF BENEFITS - PRESCRIPTION DRUGS

You are required to pay the following:

Non- Maintenance Medication

Level 1 Drugs \$10 Co-Payment per Prescription

Level 2 Drugs \$30 Co-Payment per Prescription

Level 3 Drugs \$50 Co-Payment per Prescription

Level 4 Drugs 25% Co-Payment per Prescription to a calendar year maximum Co-Payment of \$2,500 per **Covered Person** for Level 4 Drugs

Maintenance Medication

For up to a 90-day supply of a Maintenance Medication, the **Covered Person** must pay three (3) time(s) the applicable Co-Payment, subject to one Co-Payment for up to a 30-day supply.

Non-Participating pharmacy

When a Non-Participating Pharmacy is used or when a **Covered Person** does not present his or her I.D. card at the time of purchase to the **Participating Pharmacy** the **Covered Person** will also be responsible for 30% of the actual charge made by the dispensing Pharmacy, after the applicable Co-Payment or Coinsurance.

SUPPLEMENTAL BENEFIT PRESCRIPTION DRUG BENEFIT (continued)

DEFINITIONS

The following are definitions of terms as they are used in this rider.

BRAND-NAME MEDICATION

Brand-Name Medication means Prescription drugs, medicines, or medications that are manufactured and distributed by only one pharmaceutical manufacturer, or as defined by the national pricing standard used by Us.

CO-PAYMENT

Co-Payment means the amount to be paid by the Covered Person toward the cost of each separate Prescription or refill of a covered drug when dispensed by a Pharmacy.

DISPENSING LIMIT

Dispensing Limit means the monthly drug dosage limit and /or the number of months the drug usage is usually needed to treat a particular condition.

GENERIC MEDICATION

Generic Medication means drugs, medicines or medications that are manufactured, distributed and available from several pharmaceutical manufacturers and identified by the chemical name; or as defined by the national pricing standard used by Us.

LEGEND DRUG

Legend Drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: "Caution: Federal Law Prohibits dispensing without prescription".

LEVEL 1, 2, 3 or 4 DRUGS

Level 1 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by Us as Level 1 Drugs.

Level 2 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by Us as Level 2 Drugs.

Level 3 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by Us as Level 3 Drugs.

Level 4 Drugs means a category of Prescription Drugs, medicines or medications within Our Drug List that are designated by Us as Level 4 Drugs.

MAINTENANCE MEDICATION

Maintenance Medication means Prescription drugs, medicines or medications that are:

1. Generally prescribed for treatment of long-term chronic Sickness or Bodily Injuries; and
2. Purchased from the Pharmacy contracted by Us to dispense drugs by mail order.

SUPPLEMENTAL BENEFIT PRESCRIPTION DRUG BENEFIT (continued)

Maintenance Medication does not include Self-Administered Injectable Drugs, or Level 4 Drugs as designated by Us.

NON-PARTICIPATING PHARMACY

Non-Participating Pharmacy means a Pharmacy which has not entered into a service agreement with Us.

OUR DRUG LIST

Our Drug List means a list of Prescription drugs, medicines and medications and supplies specified by Us. This list is subject to change.

PARTICIPATING PHARMACY

Participating Pharmacy means a Pharmacy which has entered into a service agreement with Us to provide services under the terms set forth by Us.

PHARMACIST

Pharmacist means a person who is licensed to prepare and dispense medication and who is practicing within the scope of his or her license.

PHARMACY

Pharmacy means a licensed establishment where prescription medications are dispensed by a Pharmacist.

PRESCRIPTION

Prescription means a direct order for the preparation and use of a drug, medicine or medication. The drug, medicine or medication must be obtainable only by Prescription.

The Prescription must be given by a **Qualified Practitioner** to a Pharmacist for the benefit of and use by a **Covered Person** for the treatment of a **Bodily Injury** or **Sickness**. The Prescription may be given to the Pharmacist verbally or in writing by the **Qualified Practitioner**.

The Prescription must include:

1. The name and address of the **Covered Person** for whom the Prescription is intended;
2. The type and quantity of the drug, medicine or medication prescribed, and the directions for its use;
3. The date the Prescription was prescribed; and
4. The name, address and DEA number of the prescribing **Qualified Practitioner**.

PRIOR AUTHORIZATION

Prior Authorization means the required prior approval from Us for the coverage of Prescription drugs, medicines, medications, including the dosage, quantity and duration, as appropriate for the **Covered Person's** age and sex. Certain Prescription drugs, medicines or medications may require Prior Authorization.

SUPPLEMENTAL BENEFIT PRESCRIPTION DRUG BENEFIT (continued)

SELF-ADMINISTERED INJECTABLE DRUG

Self-Administered Injectable Drug means an FDA approved medication which a person may administer to himself/herself by means of intramuscular, intravenous, or subcutaneous injection, (excluding insulin, epinephrine, sumatriptan, and glucagon) and intended for use by the **Covered Person**.

COVERAGE DESCRIPTION

Benefits are available for covered Prescription drugs, medicines or medications that are received by the **Covered Person** while he or she is covered under this Prescription Drug Benefit Rider. Benefits may be subject to Dispensing Limits and Prior Authorization requirements, if any.

Covered Prescriptions are:

1. Drugs, medicines or medications that under federal or state law, may be dispensed only by Prescription from a **Qualified Practitioner**; and
2. Limited to a maximum of a 30-day supply for a Non-Maintenance Medication per Prescription or refill (the maximum is a 30-day supply per Co-Payment based on the FDA approved dosage, regardless of manufacturers' packaging, e.g. a 90-day supply of pre-packaged inhalers would require 3 Co-Payments); and
3. Limited to a maximum of a 90-day supply for Maintenance Medication per Prescription or refill; and
4. Drugs, medicines or medications that must be included on Our Drug List; and
5. Insulin and diabetic supplies (on Prescription), which include:
 - A. Strips;
 - B. Glucose tabs;
 - C. Lancets and lancet devices;
 - D. Test solutions;
 - E. Syringes;
 - F. Alcohol swabs;
 - G. Insulin delivery devices; and
 - H. Blood glucose monitors;
6. Hypodermic needles or syringes on Prescription for use with insulin or Self-Administered Injectable Drugs; (Hypodermic needles and syringes used in conjunction with covered Level 4 Drugs may be available at no cost to You);
7. Self-Administered Injectable Drugs approved by Us; and
8. Spacers and/or peak flow meters for the treatment of asthma.

SUPPLEMENTAL BENEFIT PRESCRIPTION DRUG BENEFIT (continued)

Contrary to any other provisions of the Policy, We may decline coverage or, if applicable, exclude from Our Drug List any and all Legend Drugs during a review period not to exceed six(6) months following FDA approval for the use and release of the Legend Drugs into the market. After the review period, a determination will be made regarding coverage status and inclusion of the Legend Drugs on Our Drug List.

ADDITIONAL LIMITATIONS AND EXCLUSIONS

Expense Incurred will not be payable under this Rider for the following:

1. Legend Drugs which are not recommended and not deemed necessary by a **Qualified Practitioner**;
2. Any drug prescribed for intended use other than for:
 - A. Indications approved by the FDA; or
 - B. Recognized off-label indications through peer-reviewed medical literature;
3. Any drug prescribed for a **Sickness or Bodily Injury** not covered under the Policy;
4. Any drug, medicine or medication labeled "Caution - Limited by Federal Law to Investigational Use" or any experimental drug, medicine or medication, even though a charge is made to the Covered Person;
5. Allergen extracts;
6. Therapeutic devices or appliances, including:
 - A. Hypodermic needles and syringes except needles and syringes for diabetes, and Self-Administered Injectable Drugs approved by Us;
 - B. Support garments;
 - C. Test reagents;
 - D. Mechanical pumps for delivery of medications; and
 - E. Other non-medical substances;
7. Dietary supplements;
8. Nutritional products;
9. Fluoride supplements;
10. Minerals;
11. Growth hormones (medications, drugs or hormones to stimulate growth), unless there is a laboratory confirmed diagnosis of growth hormone deficiency;

**SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)**

12. Herbs and vitamins, except prenatal (including greater than one milligram of folic acid) and pediatric multi-vitamins with fluoride;
13. Anabolic steroids;
14. Anorectic or any drug used for the purpose of weight control;
15. Any drug used for cosmetic purposes, including but not limited to:
 - A. Tretinoin, e.g. Retin A, except if You are under the age of 45 or are diagnosed as having adult acne;
 - B. Dermatologicals or hair growth stimulants; or
 - C. Pigmenting or de-pigmenting agents, e.g. Solaquin;
16. Any drug or medicine that is:
 - A. Lawfully obtainable without a Prescription (over the counter drugs), except Insulin; or
 - B. Available in prescription strength without a Prescription;
17. Compounded drugs in any dosage form; except when prescribed for pediatric use for children up to 19 years of age;
18. Progesterone crystals or powder in any compounded dosage form;
19. Abortifacients (drugs used to induce abortions);
20. Infertility Services including medications;
21. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;
22. Any oral drug, medicine or medication that is consumed or injected, at the place where the Prescription is given or dispensed by the **Qualified Practitioner**;
23. The administration of covered medication;
24. Prescriptions that are to be taken by or administered to the **Covered Person**, in whole or in part, while he or she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. Inpatient facilities include, but are not limited to:
 - A. **Hospital**;
 - B. Rest home;
 - C. Sanitarium;
 - D. **Skilled Nursing Facility**;
 - E. Convalescent Hospital; or
 - F. **Hospice Facility**;

**SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)**

25. Injectable drugs, including but not limited to:
- A. Immunizing agents;
 - B. Biological sera;
 - C. Blood;
 - D. Blood plasma; or
 - E. Self-Administered Injectable Drugs not approved by Us;
26. Prescription refills:
- A. In excess of the number specified by the **Qualified Practitioner**; or
 - B. Dispensed more than one year from the date of the original order;
27. Any portion of a Prescription or refill that exceeds a 30-day supply for a Non-Maintenance Medication (or a 90-day supply for a Maintenance Medication by mail order);
28. Any portion of a Prescription or refill that:
- A. Exceeds Our drug specific Dispensing Limit, e.g. IMITREX; or
 - B. Is dispensed to a **Covered Person** whose age is outside the drug specific age limits defined by Us;
 - C. Exceeds the duration-specific Dispensing Limit (e.g. use of a proton pump inhibitor such as Prevacid for more than 60 or 90 days);
29. Any drug for which Prior Authorization is required, as determined by Us, and not obtained;
30. Any drug for which a charge is customarily not made, or for which the dispenser's charge is less than the Co-Payment amount in the absence of this benefit;
31. Any drug, medicine or medication received by the **Covered Person**:
- A. Before becoming covered under this Rider; or
 - B. After the date the **Covered Person's** coverage under this Rider has ended;
32. Any costs related to the mailing, sending or delivery of prescription drugs;
33. Any fraudulent misuse of this benefit, including Prescriptions purchased for consumption by someone other than the **Covered Person**;
34. Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;

**SUPPLEMENTAL BENEFIT
PRESCRIPTION DRUG BENEFIT (continued)**

- 35. Any service, supply or therapy to eliminate or reduce a dependency on, or addiction to tobacco and tobacco products, including but not limited to Nicotine withdrawal therapies, programs, services or medications;
- 36. Drug delivery implants, e.g. Norplant;
- 37. Treatment for Onychomycosis (nail fungus);
- 38. More than one Prescription for the same drug or therapeutic equivalent medication prescribed by one or more **Qualified Practitioners** and dispensed by one or more Pharmacies until at least 75% of the previous Prescription has been used by the **Covered Person**, unless the drug or therapeutic equivalent medication is a Maintenance Medication, purchased through mail order, in which case 66% of the previous Prescription must have been used by the **Covered Person** (based on the dosage schedule prescribed by the **Qualified Practitioner**);
- 39. Any drug or biological that has received designation as an orphan drug, unless approved by Us; or
- 40. Any Co-Payments or Coinsurance You paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription.



Michael B. McCallister
President

AMENDMENT

This amendment is made part of the Policy to which it is attached. The effective date of this change is the later of the effective date of the Certificate or the date this amendment is added to the Policy.

All terms used in this amendment have the same meaning given to them in the Policy unless otherwise specifically defined in this amendment. Except as modified below all Policy terms, conditions and limitations apply.

PRAUTHORIZATION REQUIREMENTS AND PENALTY

Notwithstanding any provision of the Policy, the following **Preauthorization** requirements now apply:

Preauthorization by Us is required for certain **Services** and supplies. Visit **Our Website** at www.humana.com or call the customer service telephone number on **Your** identification card to obtain a list of **Services** and supplies that require **Preauthorization**. The list of **Services** and supplies that require **Preauthorization** is subject to change. Coverage provided in the past for **Services** or supplies that did not receive or require **Preauthorization**, is not a guarantee of future coverage of the same **Services** or supplies.

You are responsible for informing **Your Qualified Practitioner** of the **Preauthorization** requirements. **You** or **Your Qualified Practitioner** must contact **Us** by telephone, electronic mail, via **Our Website** or in writing to request the appropriate authorization. **Your ID** card will show **Your Qualified Practitioner** the telephone number to call to request authorization. Benefits are not paid at all for **Services** or supplies that are not **Covered Expenses**.

If any required **Preauthorization** of **Services** or supplies is not obtained, the benefit payable for any **Covered Expenses** incurred for the **Services**, will be reduced by \$500 or 50%, whichever is less, after any applicable **Deductibles** or co-payments. If the rendered **Services** are not **Covered Expenses**, no benefits are payable. The out-of-pocket amounts incurred by the **You** due to these benefit reductions may not be used to satisfy any out-of-pocket limits. This **Preauthorization** penalty will apply if **You** received the **Services** from either a Preferred Provider or a Non-Preferred Provider when **Preauthorization** is required and not obtained.

LIMITATIONS AND EXCLUSIONS

The following exclusion is added to **Your Policy**:

Services received in an emergency room unless required because of an **Emergency Care**.

Humana Insurance Company



Michael B. McCallister
President

HUMANA.
Guidance when you need it most

Toll Free: 800-558-4444
1100 Employers Blvd.
Green Bay, WI 54344
www.humana.com

INSURED BY
HUMANA INSURANCE COMPANY

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION LAW

Residents of Illinois who purchase health insurance, life insurance, and annuities should know that the insurance companies licensed in Illinois to write these types of insurance are members of the Illinois Life and Health Insurance Guaranty Association. The purpose of this Guaranty Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its policy obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the covered claims of policyholders that live in Illinois (and their payees, beneficiaries, and assignees) and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, as noted below.

ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

DISCLAIMER

The Illinois Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are substantial limitations and exclusions. Coverage is generally conditioned on continued residence in Illinois. Other conditions may also preclude coverage.

You should not rely on availability of coverage under the Life and Health Insurance Guaranty Association Law when selecting an insurer. Your insurer and agent are prohibited by law from using the existence of the Association or its coverage to sell you an insurance policy.

The Illinois Life and Health Insurance Guaranty Association or the Illinois Department of Insurance will respond to any questions you may have which are not answered by this document. Policyholders with additional questions may contact:

Illinois Life and Health Insurance Guaranty Association
8420 West Bryn Mawr Avenue
Chicago, Illinois 60631
(773) 714-8050

Illinois Department of Insurance
320 West Washington Street, 4th Floor
Springfield, Illinois 62767
(217) 782-4515

Summary of General Purposes And Current Limitations of Coverage

The Illinois law that provides for this safety-net coverage is called the Illinois Life and Health Insurance Guaranty Association Law ("Law") (215 ILCS 5/531.01, et seq.). The following contains a brief summary of the Law's coverages, exclusions, and limits. This summary does not cover all provisions, nor does it in any way change anyone's rights or obligations under the Law or the rights or obligations of the Guaranty Association. If you have obtained this document from an agent in connection with the purchase of a policy, you should be aware that its delivery to you does not guarantee that your policy is covered by the Guaranty Association.

- Coverage:
 - The Illinois Life and Health Insurance Guaranty Association provides coverage to policyholders that reside in Illinois for insurance issued by members of the Guaranty Association, including:
 - Life insurance, health insurance, and annuity contracts;
 - Life, health or annuity certificates under direct group policies or contracts;
 - Unallocated annuity contracts; and
 - Contracts to furnish health care services and subscription certificates for medical or health care services issued by certain licensed entities. The beneficiaries, payees, or assignees of such persons are also protected, even if they live in another state.
- Exclusions from Coverage
 - The Guaranty Association does not provide coverage for:
 - Any policy or portion of a policy for which the individual has assumed the risk;
 - Any policy of reinsurance (unless an assumption certificate was issued);
 - Interest rate guarantees which exceed certain statutory limitations;
 - Certain unallocated annuity contracts issued to an employee benefit plan protected under the Pension Benefit Guaranty Corporation and any portion of a contract which is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;
 - Any portion of a variable life insurance or variable annuity contract not guaranteed by an insurer; or
 - Any stop loss insurance.
 - In addition, persons are not protected by the Guaranty Association if:

- The Illinois Director of Insurance determines that, in the case of an insurer which is not domiciled in Illinois, the insurer's home state provides substantially similar protection to Illinois residents which will be provided in a timely manner; or
 - Their policy was issued by an organization which is not a member insurer of the Association.
- Limits on Amount of Coverage:
 - The Law also limits the amount the Illinois Life and Health Insurance Guaranty Association is obligated to pay. the Guaranty Association's liability is limited to the lesser of either:
 - The contractual obligations for which the insurer is liable for which the insurer would have been liable if it were not an impaired or insolvent insurer, or
 - With respect to any one life, regardless of the number of policies, contracts, or certificates:
 - In the case of life insurance, \$300,000 in death benefits but not more than \$100,000 in net cash surrender or withdrawal values;
 - In the case of health insurance, \$300,000 in health insurance benefits, including net cash surrender or withdrawal values; and
 - With respect to annuities, \$100,000 in the present value of annuity benefits, including net cash surrender or withdrawal values, and \$100,000 in the present value of annuity benefits for individuals participating in certain government retirement plans covered by an unallocated annuity contract. The limit for coverage of unallocated annuity contracts other than those issued to certain governmental retirement plans is \$5,000,000 in benefits per contract holder, regardless of the number of contracts.
 - However, in no event is the Guaranty Association liable for more than \$300,000 with respect to any one individual.

IMPORTANT NOTICE

If You are not satisfied with the determination by Us or a utilization review agent regarding services furnished or proposed to be furnished to You, You have the right to request an internal or external review, as applicable.

Prior to requesting an external review, the Covered Person must first exhaust the internal grievance process, with the following exceptions:

If the Covered Person has a medical condition that would seriously jeopardize his/her health or ability to regain maximum function the Covered Person or his/her designated representative may file a request for an expedited external review at the same time that a similar request is being made for an expedited internal grievance.

If We do not respond to an individual's internal grievance within 35 calendar days of the written submission, and without any agreement or request by the Covered Person or his/her designated representative to grant a delay, the Covered Person may file a request for an external review; then the Covered Person will be considered to have exhausted Our internal grievance process.

Upon filing request for an external review, the individual will be required to sign an authorization for the release of any pertinent medical records that may be necessary to adequately review his/her case.

You may call Humana Insurance Company's toll free telephone number at

1-800-558-4444

or write to Humana Insurance Company at

Humana Grievance & Appeals Office
P.O. Box 14618
Lexington, KY 40512-4618

You may contact the Commissioner of Insurance for assistance at any time at

PO BOX 30220
Lansing, MI 48909-7720

PHONE: 1-877-999-6442
FAX: (517) 241-4168

NOTICES

The following pages contain important information about Humana's claims procedures and certain federal laws. There may be differences between the Certificate of Insurance and this Notice packet. The Plan participant is eligible for the rights more beneficial to the participant.

This section includes notices about:

Claims and Appeal Procedures

Federal Legislation

Women's Health and Cancer Rights Act

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

Medical Child Support Orders

General Notice of COBRA Continuation of Coverage Rights

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)

Family And Medical Leave Act (FMLA)

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Your Rights Under ERISA

Privacy and Confidentiality Statement

NOTICES (continued)

Claims and appeals procedures

Federal standards

The Employee Retirement Income Security Act of 1974 (ERISA) established minimum requirements for claims procedures. Humana complies with these standards. Covered persons in insured plans subject to ERISA should also consult their insurance benefit plan documents (e.g., the Certificate of Insurance or Evidence of Coverage). Humana complies with the requirements set forth in any such benefit plan document issued by it with respect to the plan unless doing so would prevent compliance with the requirements of the federal ERISA statute and the regulations issued there under. The following claims procedures are intended to comply with the ERISA claims regulation, and should be interpreted consistent with the minimum requirements of that regulation. Covered persons in plans not subject to ERISA, should consult their benefit plan documents for the applicable claims and appeals procedures.

Discretionary authority

With respect to paying claims for benefits or determining eligibility for coverage under a policy issued by Humana, Humana as administrator for claims determinations and as ERISA claims review fiduciary, shall have full and exclusive discretionary authority to:

- Interpret plan provisions;
- Make decisions regarding eligibility for coverage and benefits, and
- Resolve factual questions relating to coverage and benefits.

Definitions

Adverse determination means a decision to deny benefits for a *pre-service claim* or a *post-service claim* under a *group health plan*.

Claimant means a covered person (or authorized representative) who files a claim.

Concurrent-care decision means a decision by the plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the plan (other than by plan amendment or termination) or a decision with respect to a request by a Claimant to extend a course of treatment beyond the period of time or number of treatments that has been approved by the plan.

Group health plan means an employee welfare benefit plan to the extent the plan provides medical care to employees or their dependents directly (self insured) or through insurance (including HMO plans), reimbursement or otherwise.

Health insurance issuer means the offering company listed on the face page of your Certificate of Insurance and referred to in this document as "Humana."

Post-service claim means any claim for a benefit under a *group health plan* that is not a *pre-service claim*.

NOTICES (continued)

Pre-service claim means a request for authorization of a benefit for which the plan conditions receipt of the benefit, in whole or in part, on advance approval.

Urgent-care claim (expedited review) means a claim for covered services to which the application of the time periods for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
- In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the service that is the subject of the claim.

Humana will make a determination of whether a claim is an *urgent-care claim*. However, any claim a physician, with knowledge of a covered person's medical condition, determines is a "*urgent-care claim*" will be treated as a "claim involving urgent care."

Submitting a claim

This section describes how a *claimant* files a claim for plan benefits. A claim must be filed in writing and delivered by mail, postage prepaid, by FAX or e-mail. A request for pre-authorization may be filed by telephone. The claim or request for pre-authorization must be submitted to Humana or to Humana's designee at the address indicated in the covered person's benefit plan document or identification card. This is particularly important with respect to mental health coordinators and other providers to whom Humana has delegated responsibility for claims administration. Claims will not be deemed submitted for purposes of these procedures unless and until received at the correct address.

Claims submissions must be in a format acceptable to Humana and compliant with any legal requirements. Claims not submitted in accordance with the requirements of applicable federal law respecting privacy of protected health information and/or electronic claims standards will not be accepted by Humana.

Claims submissions must be timely. Claims must be filed as soon as reasonably possible after they are incurred, and in no event later than the period of time described in the benefit plan document.

Claims submissions must be complete and delivered to the designated address. At a minimum they must include:

- Name of the covered person who incurred the covered expense;
- Name and address of the provider;
- Diagnosis;
- Procedure or nature of the treatment;
- Place of service;
- Date of service; and
- Billed amount.

NOTICES (continued)

Presentation of a prescription to a pharmacy does not constitute a claim for benefits under the plan. If a covered person is required to pay the cost of a covered prescription drug, he or she may submit a written claim for plan benefits to Humana.

A general request for an interpretation of plan provisions will not be considered a claim. Requests of this type, such as a request for an interpretation of the eligibility provisions of the plan, should be directed to the plan administrator.

Failure to provide necessary information

If a *pre-service claim* submission is not made in accordance with the plan's requirements, Humana will notify the *claimant* of the problem and how it may be remedied within five (5) days (or within 24 hours, in the case of an *urgent-care claim*). If a *post-service claim* is not made in accordance with the plan's requirement, it will be returned to the submitter.

Authorized representatives

A covered person may designate an authorized representative to act on his or her behalf in pursuing a benefit claim or appeal. The authorization must be in writing and authorize disclosure of health information. If a document is not sufficient to constitute designation of an authorized representative, as determined by Humana, the plan will not consider a designation to have been made. An assignment of benefits does not constitute designation of an authorized representative.

Any document designating an authorized representative must be submitted to Humana in advance or at the time an authorized representative commences a course of action on behalf of the covered person. Humana may verify the designation with the covered person prior to recognizing authorized representative status.

In any event, a health care provider with knowledge of a covered person's medical condition acting in connection with an Urgent-care Claim will be recognized by the plan as the covered person's authorized representative.

Covered persons should carefully consider whether to designate an authorized representative. Circumstances may arise under which an authorized representative may make decisions independent of the covered person, such as whether and how to appeal a claim denial.

Claims decisions

After a determination on a claim is made, Humana will notify the *claimant* within a reasonable time, as follows:

- *Pre-service claims* - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 15 days after the plan receives of the claim.

NOTICES (continued)

This period may be extended by an additional 15 days, if Humana determines the extension is necessary due to matters beyond the control of the plan. Before the end of the initial 15-day period, Humana will notify the *claimant* of the circumstances requiring the extension and the date by which Humana expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the *claimant* will have at least 45 days from the date the notice is received to provide the necessary information.

- *Urgent-care claims (expedited review)* - Humana will determine whether a particular claim is an *urgent-care claim*. This determination will be based on information furnished by or on behalf of a covered person. Humana will exercise its judgment when making the determination with deference to the judgment of a physician with knowledge of the covered person's condition. Humana may require a *claimant* to clarify the medical urgency and circumstances supporting the *urgent-care claim* for expedited decision-making.

Notice of a favorable or *adverse determination* will be made by Humana as soon as possible, taking into account the medical urgency particular to the covered person's situation, but not later than 72 hours after receiving the *urgent-care claim*.

If a claim does not provide sufficient information to determine whether, or to what extent, services are covered under the plan, Humana will notify the *claimant* as soon as possible, but not more than 24 hours after receiving the *urgent-care claim*. The notice will describe the specific information necessary to complete the claim. The *claimant* will have a reasonable amount of time, taking into account the covered person's circumstances, to provide the necessary information – but not less than 48 hours.

Humana will provide notice of the plan's urgent-care claim determination as soon as possible but no more than 48 hours after the earlier of:

- The plan receives the specified information; or
 - The end of the period afforded the Claimant to provide the specified additional information.
- *Concurrent-care decisions* - Humana will notify a *claimant* of a *concurrent-care decision* involving a reduction or termination of pre-authorized benefits sufficiently in advance of the reduction or termination to allow the *claimant* to appeal and obtain a determination.

Humana will decide *urgent-care claims* involving an extension of a course of treatment as soon as possible taking into account medical circumstances. Humana will notify a *claimant* of the benefit determination, whether adverse or not, within 24 hours after the plan receives the claim, provided the claim is submitted to the plan 24 hours prior to the expiration of the prescribed period of time or number of treatments.

- *Post-service claims* - Humana will provide notice of a favorable or *adverse determination* within a reasonable time appropriate to the medical circumstances but no later than 30 days after the plan receives the claim.

NOTICES (continued)

This period may be extended an additional 15 days, if Humana determines the extension is necessary due to matters beyond the plan's control. Before the end of the initial 30-day period, Humana will notify the affected *claimant* of the extension, the circumstances requiring the extension and the date by which the plan expects to make a decision.

If the reason for the extension is because Humana does not have enough information to decide the claim, the notice of extension will describe the required information, and the claimant will have at least 45 days from the date the notice is received to provide the specified information. Humana will make a decision on the earlier of the date on which the claimant responds or the expiration of the time allowed for submission of the requested information.

Initial denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time frames noted above. With respect to adverse decisions involving *urgent-care claims*, notice may be provided to *claimants* orally within the time frames noted above. If oral notice is given, written notification must be provided no later than 3 days after oral notification.

A claims denial notice will convey the specific reason for the *adverse determination* and the specific plan provisions upon which the determination is based. The notice will also include a description of any additional information necessary to perfect the claim and an explanation of why such information is necessary. The notice will disclose if any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to *claimants*, free of charge, upon request.

The notice will describe the plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the case of an adverse decision of an *urgent-care claim*, the notice will provide a description of the plan's expedited review procedures.

Appeals of adverse determinations

A *claimant* must appeal an *adverse determination* within 180 days after receiving written notice of the denial (or partial denial). An appeal may be made by a *claimant* by means of written application to Humana, in person, or by mail, postage prepaid.

NOTICES (continued)

A *claimant*, on appeal, may request an expedited appeal of an adverse *urgent-care claim* decision orally or in writing. In such case, all necessary information, including the plan's benefit determination on review, will be transmitted between the plan and the *claimant* by telephone, facsimile, or other available similarly expeditious method, to the extent permitted by applicable law.

Determination of appeals of denied claims will be conducted promptly, will not defer to the initial determination and will not be made by the person who made the initial adverse claim determination or a subordinate of that person. The determination will take into account all comments, documents, records, and other information submitted by the *claimant* relating to the claim.

On appeal, a *claimant* may review relevant documents and may submit issues and comments in writing. A *claimant* on appeal may, upon request, discover the identity of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the *adverse determination* being appealed, as permitted under applicable law.

If the claims denial is based in whole, or in part, upon a medical judgment, including determinations as to whether a particular treatment, drug, or other service is experimental, investigational, or not medically necessary or appropriate, the person deciding the appeal will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The consulting health care professional will not be the same person who decided the initial appeal or a subordinate of that person.

Time periods for decisions on appeal

Appeals of claims denials will be decided and notice of the decision provided as follows:

- *Urgent-care claims* - As soon as possible but no later than 72 hours after Humana receives the appeal request;
- *Pre-service claims* - Within a reasonable period but no later than 30 days after Humana receives the appeal request;
- *Post-service claims* - Within a reasonable period but no later than 60 days after Humana receives the appeal request;
- *Concurrent-care decisions* - Within the time periods specified above depending on the type of claim involved.

Appeals denial notices

Notice of a claim denial (including a partial denial) will be provided to *claimants* by mail, postage prepaid, by FAX or by e-mail, as appropriate, within the time periods noted above.

A notice that a claim appeal has been denied will include:

- The specific reason or reasons for the *adverse determination*;

NOTICES (continued)

- Reference to the specific plan provision upon which the determination is based;
- If any internal plan rule, protocol or similar criterion was relied upon to deny the claim. A copy of the rule, protocol or similar criterion will be provided to the *claimant*, free of charge, upon request;
- A statement describing any voluntary appeal procedures offered by the plan and the *claimant's* right to obtain the information about such procedures, and a statement about the *claimant's* right to bring an action under §502(a) of ERISA;
- If an *adverse determination* is based on medical necessity, experimental treatment or similar exclusion or limitation, the notice will state that an explanation of the scientific or clinical basis for the determination will be provided, free of charge, upon request. The explanation will apply the terms of the plan to the covered person's medical circumstances.

In the event an appealed claim is denied, the *claimant* will be entitled to receive without charge reasonable access to, and copies of, any documents, records or other information that:

- Was relied upon in making the determination;
- Was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with the administrative processes and safeguards required in making the determination;
- Constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the *claimant's* diagnosis, without regard to whether the statement was relied on in making the benefit determination.

Exhaustion of remedies

Upon completion of the appeals process under this section, a *claimant* will have exhausted his or her administrative remedies under the plan. If Humana fails to complete a claim determination or appeal within the time limits set forth above, the claim shall be deemed to have been denied and the *claimant* may proceed to the next level in the review process.

After exhaustion of remedies, a *claimant* may pursue any other legal remedies available, which may include bringing civil action under ERISA section 502(a) for judicial review of the plan's determination. Additional information may be available from the local U.S. Department of Labor Office.

Legal actions and limitations

No lawsuit may be brought with respect to plan benefits until all remedies under the plan have been exhausted.

NOTICES (continued)

No lawsuit with respect to plan benefits may be brought after the expiration of the applicable limitations period stated in the benefit plan document. If no limitation is stated in the benefit plan document, then no such suit may be brought after the expiration of the applicable limitations under applicable law.

Federal legislation

Women's health and cancer rights of 1998

Required coverage for reconstructive surgery following mastectomies

Under federal law, group health plans and health insurance issuers offering group health insurance providing medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the plan.

Statement of rights under the newborn' and mothers' health protection act (NMHPA)

If your plan covers normal pregnancy benefits, the following notice applies to you.

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, group health plans and health insurance issuers may not set the level of benefits or out-of-pocket costs so any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a group health plan or health insurance issuer may not, under federal law, require a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-authorization. For information on pre-authorization, contact your plan administrator.

NOTICES (continued)

Medical child support orders

An individual who is a child of a covered employee shall be enrolled for coverage under the group health plan in accordance with the direction of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSO).

A QMCSO is a state-court order or judgment, including approval of a settlement agreement that:

- Provides for support of a covered employee's child;
- Provides for health care coverage for that child;
- Is made under state domestic relations law (including a community property law);
- Relates to benefits under the group health plan; and
- Is "qualified," i.e., it meets the technical requirements of ERISA or applicable state law.

QMCSO also means a state court order or judgment enforcing state Medicaid law regarding medical child support required by the Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993).

An NMSO is a notice issued by an appropriate agency of a state or local government that is similar to a QMCSO requiring coverage under the group health plan for a dependent child of a non-custodial parent who is (or will become) a covered person by a domestic relations order providing for health care coverage.

Procedures for determining the qualified status of medical child support orders are available at no cost upon request from the plan administrator.

General notice of COBRA continuation coverage rights

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

NOTICES (continued)

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, the qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

When is COBRA Coverage Available?

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or commencement of a proceeding in bankruptcy with respect to the employer, the employer must notify the Plan Administrator of the qualifying event.

NOTICES (continued)

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child) you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. Once the Plan Administrator offers COBRA continuation coverage, the qualified beneficiaries must elect such coverage with 60 days.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction in the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee last until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which the employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage - If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days of such determination, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage;

Second qualifying event extension of 18-month period of continuation coverage - If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is given to the Plan within 60 days of the event. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

NOTICES (continued)

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting your group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Humana
Billing/Enrollment Department
101 E Main Street
Louisville, KY 40201
1-800-872-7207

Important notice for individuals entitled to Medicare tax equity and fiscal responsibility act of 1982 (TEFRA) options

Where an employer employs more than 20 people, the Tax Equity And Fiscal Responsibility Act of 1982 (TEFRA) allows covered employees in active service who are age 65 or older and their covered spouses who are eligible for Medicare to choose one of the following options.

- *Option 1* - The benefits of their group health plan will be payable first and the benefits of Medicare will be payable second.
- *Option 2* - Medicare benefits only. The employee and his or her dependents, if any, will not be insured by the group health plan.

The employer must provide each covered employee and each covered spouse with the choice to elect one of these options at least one month before the covered employee or the insured spouse becomes age 65. All new covered employees and newly covered spouses age 65 or older must be offered these options. If Option 1 is chosen, its issue is subject to the same requirements as for an employee or dependent that is under age 65.

NOTICES (continued)

Under TEFRA regulations, there are two categories of persons eligible for Medicare. The calculation and payment of benefits by the group health plan differs for each category.

- *Category 1* Medicare eligibles are:
 - Covered employees in active service who are age 65 or older who choose Option 1;
 - Age 65 or older covered spouses; and
 - Age 65 or older covered spouses of employees in active service who are either under age 65 or age 70 or older;
- *Category 2* Medicare eligibles are any other covered persons entitled to Medicare, whether or not they enrolled. This category includes, but is not limited to:
 - Retired employees and their spouses; or
 - Covered dependents of a covered employee, other than his or her spouse.

Calculation and payment of benefits

For covered persons in Category 1, benefits are payable by the policy without regard to any benefits payable by Medicare. Medicare will then determine its benefits.

For covered persons in Category 2, Medicare benefits are payable before any benefits are payable by the policy. The benefits of the policy will then be reduced by the full amount of all Medicare benefits the covered person is entitled to receive, whether or not the eligible individual is actually enrolled for Medicare Benefits.

Family and Medical Leave Act (FMLA)

If an employee is granted a leave of absence (Leave) by the *employer* as required by the Federal Family and Medical Leave Act, s/he may continue to be covered under the plan for the duration of the Leave under the same conditions as other *employees* who are currently employed and covered by the plan. If the employee chooses to terminate coverage during the Leave, or if coverage terminates as a result of nonpayment of any required contribution, coverage may be reinstated on the date the employee returns to work immediately following the end of the Leave. Charges incurred after the date of reinstatement will be paid as if the employee had been continuously covered.

Uniformed services employment and reemployment rights act of 1994 (USERRA)

Continuation of benefits

Effective October 13, 1994, federal law requires health plans offer to continue coverage for employees that are absent due to service in the uniformed services and/or dependents.

NOTICES (continued)

Eligibility

An employee is eligible for continuation under USERRA if he or she is absent from employment because of voluntary or involuntary performance of duty in the Armed Forces, Army National Guard, Air National Guard, or commissioned corps of the Public Health Service. Duty includes absence for active duty, active duty for training, initial active duty for training, inactive duty training and for the purpose of an examination to determine fitness for duty.

An employee's dependents that have coverage under the plan immediately prior to the date of the employee's covered absence are eligible to elect continuation under USERRA.

If continuation of Plan coverage is elected under USERRA, the employee or dependent is responsible for payment of the applicable cost of coverage. If the employee is absent for not longer than 31 days, the cost will be the amount the employee would otherwise pay for coverage. For absences exceeding 30 days, the cost may be up to 102% of the cost of coverage under the plan. This includes the employee's share and any portion previously paid by the employer.

Duration of coverage

If elected, continuation coverage under USERRA will continue until the earlier of:

- 24 months beginning the first day of absence from employment due to service in the uniformed services; or
- The day after the employee fails to apply for a return to employment as required by USERRA, after the completion of a period of service.

Under federal law, the period coverage available under USERRA shall run concurrently with the COBRA period available to an employee and/or eligible dependent.

Other information

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or change of address.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

Under the Employee Retirement Income Security Act of 1974 (ERISA), all plan participants covered by ERISA are entitled to certain rights and protections, as described below. Notwithstanding anything in the group health plan or group insurance policy, following are a covered person's minimum rights under ERISA. ERISA requirements do not apply to plans maintained by governmental agencies or churches.

NOTICES (continued)

Participants should review their group health plan document regarding reduction or elimination of exclusionary periods for preexisting conditions due to creditable coverage from another plan. The group health plan or health insurance issuer should provide a certificate of creditable coverage when coverage ends under the plan, the participant becomes entitled to elect COBRA continuation coverage, COBRA continuation coverage ceases (if COBRA is requested before losing coverage) or, if requested, up to 24 months after losing coverage. Without evidence of creditable coverage, a participant may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after the coverage enrollment date.

Claims determinations

If a claim for a plan benefit is denied or disregarded, in whole or in part, participants have the right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial within certain time schedules.

Enforce your rights

Under ERISA, there are steps participants may take to enforce the above rights. For instance:

- If a participant requests a copy of plan documents does not receive them within 30 days, the participant may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until the participant receives the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If a claim for benefits is denied or disregarded, in whole or in part, the participant may file suit in a state or Federal court;
- If the participant disagrees with the plan's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, the participant may file suit in Federal court;
- If plan fiduciaries misuse the plan's money, or if participants are discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or may file suit in a Federal court.

The court will decide who should pay court costs and legal fees. If the participant is successful, the court may order the person sued to pay costs and fees. If the participant loses, the court may order the participant to pay the costs and fees.

Assistance with questions

- Contact the group health plan human resources department or the plan administrator with questions about the plan;

NOTICES (continued)

For questions about ERISA rights, contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

The Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210;

- Call the publications hotline of the Employee Benefits Security Administration to obtain publications about ERISA rights.

Privacy and confidentiality statement

We understand the importance of keeping your personal and health information private (PHI). PHI includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. We are required by applicable federal and state law to maintain the privacy of your PHI.

Under both law and our policies, we have a responsibility to protect the privacy of your PHI. We:

- Protect your privacy by limiting who may see your PHI;
- Limit how we may use or disclose your PHI;
- Inform you of our legal duties with respect to your PHI;
- Explain our privacy policies; and
- Strictly adhere to the policies currently in effect.

We reserve the right to change our privacy practices at any time, as allowed by applicable law, rules and regulations. We reserve the right to make changes in our privacy practices for all PHI that we maintain, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will send notice to our health plan subscribers. For more information about our privacy practices, please contact us.

As a covered person, we may use and disclose your PHI, without your consent/authorization, in the following ways:

Treatment: We may disclose your PHI to a health care practitioner, a hospital or other entity which asks for it in order for you to receive medical treatment.

Payment: We may use and disclose your PHI to pay claims for covered services provided to you by health care practitioners, hospitals or other entities.

NOTICES (continued)

We may use and disclose your PHI to conduct other health care operations activities.

It has always been our goal to ensure the protection and integrity of your personal and health information. Therefore, we will notify you of any potential situations where your identification would be used for reasons other than treatment, payment and health plan operations.

Mary Ann Hertz
932 ½ Judson Ave. Apt. 2-S
Evanston, IL 60202
Ph: 847-425-5907 e-mail: HertzMA@aol.com

August 8, 2007

Humana Inc.
101 East Main Street
P. O. Box 740021
Louisville, KY 40201-7421
Attn: Tonia Martin

Re: Insurance coverage

Dear Tonia:

I have just received the enclosed letter from your office (I was in a rehabilitation facility until August 4, 2007); however I have not sent in such a request before this.

This is the first time I am applying for continuation of coverage and I am doing so pursuant to my employer's instructions. I was told to send the check to their office and the application to Humana.

I am waiting for a wheelchair and it will not be delivered without insurance coverage. I was employed, and covered by Humana on the date I broke my ankle, July 15, 2007.

Please contact Shari Slavin at Slavin and Slavin, 312-782-7848, should you have any questions about the office's policy. Thank you.

Yours truly,

Mary Ann Hertz

Enc.
CC: Shari Slavin

Exhibit C



Weinberg Law Group

2446 North Clark Street ~ Chicago, Illinois 60614 ~ Ph: (773) 296-4900 ~ Fax: (773) 296-4949

February 18, 2008

Humana Grievance & Appeals Office
PO Box 14618
Lexington, KY 40512-4618

RE: Mary Ann Hertz
Humana Member ID: 003796940

Dear Sir or Madam:

The purpose of this letter is to appeal the determination made by Humana that the above-referenced member was not eligible for continuation coverage.

In the Notice packet, it states "After a qualifying event, COBRA continuation coverage must be offered to each person who is a 'qualified beneficiary.' If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens: • Your hours of employment are reduced; or • Your employment ends for any reason other than gross misconduct."

Ms. Hertz was an employee, and her employment ended for a reason other than gross misconduct. Therefore, according to the Notice packet, she was entitled to continuation coverage.

According to the Notices provided to Ms. Hertz, "There may be differences between the Certificate of Insurance and this Notice packet. The Plan participant is eligible for the rights more beneficial to the participant." Ms. Hertz was eligible for continuation

Exhibit D

February 18, 2008

RE: Mary Ann Hertz

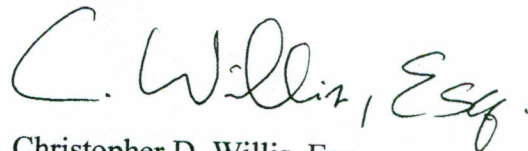
Page Two

coverage under the terms of the Notice packet, which did not include any restrictions based on the length of enrollment in the plan. Accordingly, the provisions of the Certificate of Insurance which purport to restrict eligibility for continuation coverage to employees who have been enrolled in the Plan for three months or more are not applicable to Ms. Hertz, as the provisions of the Notices are more beneficial to her.

Additionally, the notification provided to Ms. Hertz of Humana's determination regarding her eligibility for continuation coverage did not comply with the applicable regulations, including, but not limited to, 29 C.F.R. §2560.503-1(g), which requires that the notification include a description of the plan's review procedures and the time limits applicable to such procedures. The appropriate remedy for this failure is a retroactive reinstatement of Ms. Hertz's benefits. See Schneider v. Sentry Group Long Term Disability Plan, 422 F.3d 621 (7th Cir. 2005).

Please advise me as soon as possible of your determinations regarding these matters, and do not hesitate to contact me with any questions.

Always,

A handwritten signature in black ink, reading "C. Willis, Esq." in a cursive style.

Christopher D. Willis, Esq.